



OFFICE OF MEDICAID POLICY AND  
PLANNING

DIVISION OF DISABILITY AND  
REHABILITATIVE SERVICES

DIVISION OF AGING

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# Home and Community Based Services Waiver Provider Manual

Home and Community Based Services Waiver Provider Manual

This manual is the authorized reference document for Indiana Medicaid HCBS Waiver service providers and the administration of those programs.

February 13, 2007

Address any comments concerning the contents of this manual to:

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## Section 1: Introduction

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### Overview

Section 1915(c) of the Social Security Act permits States to offer, under a waiver of statutory requirements, an array of home and community based services that an individual needs to avoid institutionalization. The state of Indiana administers five home and community based waivers.

The purpose of this manual is to provide a primary reference document for home and community based services (HCBS) Medicaid waiver providers. The manual provides instruction to case managers, other service providers, state staff, family members, advocates, and waiver participants and is available to assist all those who administer, manage, and participate in Indiana's HCBS waiver programs. The information and direction in this manual replaces all previous waiver manuals. Individuals and their families may find additional information in the Indiana Medicaid HCBS Waiver Guide for Consumers courtesy of the Indiana Governor's Planning Council for People with Disabilities and found at <http://www.in.gov/gpcpd/publications/>

### Indiana Health Coverage Programs Waiver Provider Responsibilities

#### *IHCP Provider Agreement*

Waiver providers are enrolled in the Indiana Health Coverage Programs (IHCP) and have executed an *IHCP Provider Agreement* with the Indiana Family and Social Services Administration (IFSSA). This agreement states that the provider will comply, on a continuing basis, with all of the federal and state statutes and regulations pertaining to the IHCP, including the HCBS waiver programs' rules and regulations. Forms are available on the IHCP Web site at <http://www.indianamedicaid.com/ihcp/Publications/forms.asp>. By signing the agreement, the provider agrees to follow the information provided in the *IHCP Provider Manual*, as amended periodically, and the *HCBS Waiver Provider Manual*, as amended periodically, as well as all provider bulletins and notices. All amendments to the *IHCP Provider Manual*, *HCBS Waiver Provider Manual*, all applicable Indiana Administrative Codes (IACs), Rules, and Regulations are binding upon receipt or publication. Receipt of all information is presumed when mailed to the billing provider's current mail to address on file with the IFSSA or its fiscal agent.

#### *Provider Record Updates*

To ensure timely communication of all information, providers must notify the IFSSA and its fiscal agent when enrollment record information changes. Provider information is stored in two systems, IndianaAIM and INsite. IndianaAIM is maintained by the fiscal agent and INsite is maintained by IFSSA.

IndianaAIM is the Medicaid Management Information System (MMIS). The fiscal agent is responsible for maintaining IndianaAIM; therefore, the fiscal agent must have accurate pay to, mail to, and service location information on file for all providers. It is the provider's responsibility to ensure the information on file with the fiscal agent is correct. Providers are required to submit address and telephone change information to the fiscal agent within ten days of any change. Forms are available on the IHCP Web site at <http://www.indianamedicaid.com/ihcp/Publications/forms.asp>.

INsite is the system that stores client eligibility information along with the client's cost comparison budget (CCBs), notice of action (NOAs), individualized support plans (ISPs), Level of Care (LOC) information, and case notes entered by Case Managers for individual clients. INsite also has a provider database that is maintained by Medicaid Waiver Provider Specialists and is intended to provide up to date information to the field about the certification status of waiver providers. Provider selection profiles (pick lists) are generated from INsite; therefore, it is very important that the information listed is the most current and up to date information. Provider information changes must be made by contacting the appropriate provider specialist at IFSSA.

## **Provider Responsibilities Specific to the Waiver Program**

Providers must understand the service definitions and parameters for each service authorized on the NOA. If the services provided are not in agreement with the services authorized or the level of medical necessity indicated on the approved NOA, the provider must contact the case manager to discuss revising the NOA. If a service requires prior authorization (PA) through the State Plan, it is the provider's responsibility to obtain an appropriate PA denial before filing a claim for the service. An appropriate PA denial must be related to the actual service and not related to the PA process. For example, a PA denial with the reason, *provider did not submit required documentation*, would not be considered an appropriate PA denial.

## ***Provider Application Process – For the Provision of Nursing Facility Waiver Services***

- Prospective provider requests application packet from the Division of Aging (DA). Requests should be directed to the Waiver Provider Specialist, DA. An information and application packet (with accompanying attachments) is sent to the prospective provider.
- When a completed application is received, it is date stamped and reviewed by the provider specialist.
- If additional information is needed, letter goes out with request for additional information. A 30-day timeframe is given for submission of additional information.
- If information is sufficient and meets the requirements for specific service(s), (first time or after request goes out), the provider is certified for the requested service(s).
- Preliminary information is entered into the waiver provider database and a cover letter with a certification is sent to the provider. The cover letter directs the provider to contact the fiscal agent for the IHCP application to complete the Medicaid provider enrollment process. The applicant is instructed to attach the DA waiver certification to the IHCP application for processing.
- When the fiscal agent receives the completed IHCP application packet, it is processed, and if approved, Medicaid Provider status is given, the fiscal agent assigns a provider number. (If everything is not in order, a request is made by the fiscal agent to the prospective provider to complete the application process.)
- When the provider is successfully enrolled and a provider number is assigned, the fiscal agent notifies the DA provider Specialist, and the new provider is activated in the provider database.
- If a provider number is not assigned in six (6) months (meaning the applicant did not complete the IHCP application process), a letter with a required timeframe for response is sent by Waiver Provider Specialist to the provider applicant to ascertain if there is still interest in pursuing the application process.
- If there is no response in the required timeframe, the provider applicant is terminated in the provider database.

## **Provider Application Process – for the provision of ICF-MR Waiver Services**

Attendance at an Orientation Session for new prospective providers of Bureau of Developmental Disabilities Services (BDDS) services is required. This session will include presentations by the BDDS and the Bureau of Quality Improvement Services (BQIS).

There are two different orientation sessions:

- Information regarding: Adult Day Services Level 1,2, and 3, Adult Foster Care, Level 1,2, and 3, Community Transition Supports, Crisis Assistance Services, Day Services, Family and Caregiver Training Services, Rent/Food for Unrelated Live-In Caregiver Services, Residential Habilitation and Support-Daily, Respite Care Services,
- Information regarding: Applied Behavioral Analysis, Behavioral Support Services Level 1 and 2, Case Management, Environmental Modifications, Music Therapy, Occupational Therapy, Physical Therapy, Recreational Therapy, Respite, Specialized Medical Equipment and Supplies (SMES)(including vehicle modifications), SMES Assessment, Inspection and Training, Speech-Language Therapy, Therapy Services.

The orientation sessions are scheduled every quarter of the calendar year. Acceptance of applications will only be for a month's period following each orientation session. Application packets will be distributed to new (non-BDDS approved) providers during the orientation. A company representative must attend the mandatory orientation session to receive the application.

Existing BDDS-approved providers who desire to provide additional services may also submit applications during the appropriate acceptance period.

- Existing providers are not required to attend the orientation sessions.
- If they desire to add new services but do not attend an orientation Session, the provider may request an application form by calling the Provider Relations Specialist at FSSA.
- The caller's name must be provided as well as company name, and the application will be sent to the current address in the database.
- Keep in mind that these applications may be submitted only during the designated acceptance period.

## **Waiver Provider Enrollment**

Becoming a waiver provider begins with the IFSSA certification (in this instance "certification" denotes "approval") process and is finalized with the IHCP provider enrollment process. The appropriate IFSSA, HCBS Waiver division (which is dependent on the waiver services being provided) must certify providers of HCBS waiver services with the IHCP. Prospective providers interested in becoming certified waiver providers must contact the appropriate IFSSA, HCBS Waiver Unit.

For the ICF/MR Level of Care Waivers (DD, SSW, and AU waivers) contact should be directed to:

**Waiver Provider Specialist**  
**Bureau of Developmental Disabilities Services MS - 18**  
**402 West Washington Street, Room W453**  
**Indianapolis, IN 46204-2773**

For the Nursing Facility Level of Care Waivers (AD, TBI waivers), contact should be directed to:

**Waiver Provider Specialist**  
**Division of Aging MS - 21**  
**402 West Washington Street, Room W454**  
**Indianapolis, IN 46204-2243**

Once the IFSSA, HCBS waiver certification requirements are met, the Waiver division sends a HCBS waiver service certification letter to the provider detailing the approved services. Once the provider receives the certification letter, the enrollment process with the IHCP can begin.

Providers are required to obtain a Indiana Health Coverage Programs (IHCP) Provider Enrollment Application either from the (IHCP) Web site at <http://www.indianamedicaid.com>, or by contacting 1-877-707-5750 to request an application by mail. Providers must complete the enrollment application form and submit the completed application form along with the waiver certification letter to the following address:

**Provider Enrollment**  
**P.O. Box 7263**  
**Indianapolis, IN 46207-7263**

### **Helpful Tips for Completing the IHCP Enrollment Application**

The application form asks that you choose a business structure. As a waiver provider you are enrolled as either a sole practitioner (billing provider), or a group (a group must have members linked to the group), the members linked to the group are called rendering providers and are enrolled as a rendering provider linked to the group. Rendering providers cannot bill for services, the group bills for services identifying the rendering provider as the performer of the service. In order to be a group with members, all of the members must be certified by the appropriate HCBS waiver division.

Next you choose a type and specialty. The IHCP provider type for HCBS waiver providers is 32 (Waiver). The specialty you choose must be the one(s) you are certified by the IFSSA HCBS Waiver Provider Specialist to provide. The following list is the provider specialty number and description associated with the waiver type provider type 32:

- 350 – Aged and Disabled Waiver (AD)
- 351 – Autism Waiver (AU)
- 356 – Traumatic Brain Injury (TBI)
- 359 – Developmentally Disabled Waiver (DD)
- 360 – Support Services Waiver (SSW)

The enrollment application must be signed and submitted with the requested documentation (W-9, EFT form, Certification letter). All enrollment forms must be directed to the Provider Enrollment address listed above (address is also listed on the application form) to ensure proper processing. Enrollment documents are logged into a document tracking system and issued a document tracking number. Provider Enrollment has a dedicated staff member assigned to coordinate and handle all waiver provider enrollments and updates. This staff member works closely with IFSSA staff to ensure timely and accurate maintenance of waiver files. The staff member will review the enrollment packet to ensure completeness according to the Provider Enrollment guidelines and enter the provider's information into IndianaAIM. A provider letter will be generated and sent to the provider detailing the assigned IHCP provider billing number and enrollment information entered into IndianaAIM. Providers are encouraged to review this letter to ensure enrollment accuracy.

If the enrollment documents are incomplete, the entire enrollment packet will be returned to the provider with a letter that provides an explanation of the incomplete information. The provider will be required to complete the documentation and return the entire packet again to Provider Enrollment.

### **Waiver IHCP Provider Enrollment Updates**

Updates for the following information must be submitted to the IFSSA, HCBS Waiver Provider specialist:

- Name Changes
- Additional Service Locations (additional Service Location Addresses)
- Specialty Changes (all specialties must be certified by the IFSSA)
- Tax Identification Changes
- Changes in Ownership (CHOW)

IHCP Provider Enrollment staff member updates changes to the Service Location, Mail To, Pay To and Home Office information. Address changes to the Service Location, Mail To, Pay To, and Home Office do not require waiver certification changes. However, adding a service location address requires certification changes; therefore, any new service locations must be approved by the IFSSA, HCBS Waiver Provider Specialist before changes are made to the IndianaAIM enrollment information. IHCP Provider Enrollment staff member works directly and closely with the IFSSA, HCBS Waiver Provider Specialists (divisions) to complete and maintain provider enrollment information.

Once update certification requirements have been met for the provider, the IFSSA, HCBS Waiver division sends a waiver service certification letter to the provider detailing the approved services and instructing the provider to begin the update process with the fiscal agent.

Providers are required to obtain an IHCP Provider Enrollment Update Form from the (IHCP) Web site at <http://www.indianamedicaid.com> or by contacting the Provider Enrollment helpline at 1-877-707-5750 to request the update form. Providers must complete the update form with appropriate signature, and submit the form along with the waiver certification letter to the following address:

**Provider Enrollment**  
**P.O. Box 7263**  
**Indianapolis, IN 46207-7263**

The IHCP Provider Enrollment analyst will review the update form and documents to ensure completeness according to the Provider Enrollment guidelines and update the provider's information in IndianaAIM. An automated provider letter will be generated and submitted to the provider detailing the changes made to the enrollment record. Providers are encouraged to review this letter to ensure enrollment accuracy.

All questions regarding the status of the waiver provider's enrollment or updates can be directed to the Provider Enrollment helpline at 1-877-707-5750.

### **Provider Qualifications and Certification**

Providers must meet the qualifications required for each individual waiver program, to provide services under that waiver program. These qualifications are listed in this manual in Sections 7 through 39. Qualified providers may apply to be certified by the waiver program, and then must be enrolled as waiver providers in IndianaAIM.

## Section 2: Claims and Billing

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### Overview

The Indiana Health Coverage Programs (IHCP) offers five home and community based services (HCBS) waiver programs. These programs allow the state of Indiana's Medicaid program to provide services that would ordinarily only be provided in an institution to be provided in an individual's home or other community setting. Individuals must qualify for institutional care in order to be eligible for home and community based services. Waiver refers to the waiving of certain federal requirements that otherwise apply to Medicaid program services. For example, HCBS waiver programs are not Medicaid entitlement programs.

The Office of Medicaid Policy and Planning (OMPP) has overall policy responsibility for the waiver programs; day to day administration and operation of individual waiver programs may be delegated to other divisions of Family and Social Services Administration

### Eligibility for HCBS Waiver Services Impacts Billing

All potential waiver members must enroll in the IHCP. At this time, waiver participants may not be enrolled in managed care. To be eligible for reimbursement for waiver services, the waiver member must have an open waiver level of care status in IndianaAIM. All service providers must verify IHCP eligibility for each member prior to the initiation of services.

The Area Agencies on Aging (AAA) are the entry points for the Aged and Disabled, and Traumatic Brain Injury waivers. The Bureau of Developmental Disabilities Services (BDDS) District offices act as entry points for the Autism, Support Services and Developmental Disabilities waivers. Initial eligibility determinations (level of care) are determined at the entry point agencies. Before the level of care is recorded in IndianaAIM, the level of care and the initial Plan of Care/Cost Comparison Budget (POC/CCB) must be approved and a start date established. The level of care segment with the start date is then entered into IndianaAIM by the OMPP.

*Note: The fiscal agent cannot add or correct a waiver level of care segment in IndianaAIM nor terminate a managed care enrollment.*

### Waiver Authorization

The waiver case manager is responsible for completing the POC/CCB, which results in an approved Notice of Action (NOA). The NOA details the services and number of units to be provided, the name of the authorized provider, and the approved billing code with the appropriate modifiers. The case manager transmits this information to the waiver database (INsite). INsite communicates this data to IndianaAIM where it is stored in the prior authorization database. Claims will deny if no authorization exists on the database or if a code other than the approved code is billed. Providers are not to render or bill services without an approved NOA. It is the provider's responsibility to contact the case manager in the event there is any discrepancy in the services authorized or rendered and the approved NOA.

### Billing Instructions

HCBS waiver claims are billed on the paper CMS-1500 claim form or via the 837P electronic transaction. To submit a Medicaid waiver claim on the CMS-1500 claim form, the boxes listed in

Table 1 (on the claim form) must be completed. Table 1 (on the claim form) provides an explanation of each box. Please refer to the most current Provider Bulletin that contains The CMS-1500 claim form information, which is available on the [www.indianamedicaid.com](http://www.indianamedicaid.com) web site.

Providers are to bill services based on an approved NOA, using an appropriate procedure code, using the pricing method associated with the procedure code, such as per unit, per day, per month. Additional pricing information is available on the [www.indianamedicaid.com](http://www.indianamedicaid.com) Web site, under Fee Schedule.

- Do not bill for services before they are provided.
- If a unit of service equals 15 minutes, a minimum of eight minutes must be provided to bill for one unit.
- Activities requiring less than eight minutes may be accrued to the end of that date of service.
- At the end of the day, partial units may be rounded as follows: units totaling more than eight minutes may be rounded up and billed as one unit.
- Partial units totaling less than eight minutes may not be billed.
- Monthly units are billed at the end of the month.
- Daily units may be billed daily, weekly, or monthly.

**For the services of Residential Habilitation and Support (RHS) and Day Services provided under the ICF/MR Medicaid Waivers:**

- An annual amount is established and paid incrementally according to the number of days of service delivery.

### ***Claim Tips and Reminders***

When billing Medicaid waiver claims, provider must consider the following:

- The IHCP does not reimburse time spent by office staff billing claims.
- Providers may only bill for those services authorized on an approved NOA.
- A claim may include dates of service within the same month, do not submit a claim with dates that span across more than one month on the same claim.
- The units of service as billed to the IHCP must be substantiated by documentation in accordance with the appropriate IAC regulations and the waiver documentation standards issued by OMPP, DDRS and DA.
- Services billed to the IHCP must meet the service definitions and parameters as published in the aforementioned rules and standards.
- Updated information is disseminated through IHCP provider bulletins, (mailed to providers and posted on the IHCP Web site) DDRS and DA bulletins (sent through e-mail and posted on the state agency Web sites). Each provider is responsible for obtaining the information and implementing new or revised policies and procedures as outlined in these notices.

Refer to the *IHCP Provider Manual* for instructions on how to complete the paper CMS-1500 claim form. In addition, the fiscal agent and the OMPP recommend submitting claims electronically. Providers may submit claims electronically using Web interChange. For information about Web interChange, please refer to the IHCP Web site at [www.indianamedicaid.com](http://www.indianamedicaid.com) or contact provider assistance.



### ***Claim Voids and Replacements***

If a paid or denied claim must be adjusted (replaced), the initial claim is voided and a new claim takes the place of the old claim. If the claim was paid before the adjustment was made, any money paid is recouped by setting up an accounts receivable (AR) for the amount of the recoupment, which is identified on the remittance advice (RA).

The CMS-1500 Adjustment form is available on the IHCP Web site at [www.indianamedicaid.com](http://www.indianamedicaid.com). Instructions for completing the form are located on the site and in the *IHCP Provider Manual*.

## **Section 3: Audit Overview for the Auditing of Entities**

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### **Bureau of Quality Improvement Services Overview**

The Bureau of Quality Improvement Services (BQIS) within the Division of Disability and Rehabilitative Services (DDRS) is responsible for developing and implementing quality improvement and quality assurance systems to assure the health and welfare of individuals receiving services. BQIS is responsible for developing these systems for the Intermediate Care Facility for the Mentally Retarded (ICF/MR) level of care waivers administered by the Bureau of Developmental Disabilities Services (BDDS) (a bureau of the DDRS). Systems include the development of promulgated rules, survey of providers for compliance with established rules, compliance investigations, mortality reviews, incident reporting, and the transition of individuals from state-operated facilities to community-based services. Information about BQIS can be found at <http://www.in.gov/fssa/servicedisabl/bqis.html>.

### **Waivers – ICF/MR Level of Care**

BQIS, as the designee of the BDDS, is responsible for monitoring the Provider and Case Management Standards for Supported Living Services and Supports as detailed in *460 IAC 6* and the Standards for the Individualized Support Plans as detailed in *460 IAC 7*. BQIS monitors compliance with these standards through the use of standardized survey tools including an agency survey, residential services and supports survey and vocational/habilitation survey. Providers must be recertified every three years, and the recertification is based, in part, on the survey results. Non-compliance with the standards results in corrective action plans which are monitored by BQIS. If a provider fails to complete a corrective action plan as required in the standards, sanctions can be imposed.

For the full survey policy refer to <http://www.in.gov/fssa/servicedisabl/bqis.html>

BQIS is responsible for the implementation and monitoring of the BDDS incident reporting system. Providers are responsible for reporting incidents on the automated system. Reportable incidents are defined as: Any event or occurrence characterized by risk or uncertainty resulting in or having the potential to result in significant harm or injury to an individual or death of an individual. Incidents may include the following:

- Alleged, suspected, or actual abuse, neglect, or exploitation of an individual. An incident in this category shall also be reported to adult protective services or child protection services as applicable. The provider shall suspend staff involved in an incident from duty pending investigation by the provider.
- Death of an individual. A death shall also be reported to adult protective services or child protection services as applicable. A death shall also be reported to the BDDS' Central Office in Indianapolis, IN not later than twenty-four (24) hours after the death. For information regarding deaths requiring immediate investigation, please see DDRS Quarterly Policy Bulletin – Third Quarter, 2006.
- A service delivery site that compromises the health and safety of an individual while the individual is receiving services from the following causes:
  - A significant interruption of a major utility, such as electricity, heat, water, air conditioning, plumbing, fire alarm, or sprinkler system.

- Environmental or structural problems associated with a habitable site that compromises the health and safety of an individual, including:
  - inappropriate sanitation;
  - serious lack of cleanliness;
  - rodent or insect infestation;
  - structural damage; or
  - damage caused by flooding, tornado, or other acts of nature.
- Fire resulting in relocation, personal injury, property loss, or other health and safety concerns to or for an individual receiving services.
- Elopement of an individual.
- Suspected or actual criminal activity by:
  - a staff member, employee, or agent of a provider; or
  - an individual receiving services.
- An event with the potential for causing significant harm or injury and requiring medical or psychiatric treatments or services to or for an individual receiving services.
- Admission of an individual to a nursing facility, including respite stays.
- Injury to an individual when the origin or cause of the injury is unknown.
- A significant injury to an individual, including:
  - A fracture,
  - A burn greater than first degree,
  - choking that requires intervention, or
  - contusions or lacerations.
- An injury that occurs while an individual is restrained.
- A medication error, except for refusal to take medications, that jeopardizes an individual's health and safety, as determined by the individual's personal physician, including the following:
  - Medication given that was not prescribed or ordered for the individual.
  - Failure to administer medication as prescribed, including:
    - incorrect dosage,
    - missed medication, and
    - failure to give medication at the appropriate time.
- Inadequate staff support for an individual, including inadequate supervision, with the potential for:
  - Significant harm or injury to an individual, or
  - Death of an individual.
- Inadequate medical support for an individual, including failure to obtain:
  - Necessary medical services,
  - Routine dental or physician services, or
  - Medication timely resulting in missed medications.
- Use of any PRN medication related to an individual's behavior. An incident report related to the use of PRN medication in response to an individual's behavior must include the following information:
  - The length of time of the individual's behavior that resulted in the use of the PRN medication related to the individual's behavior.
  - A description of what precipitated the behavior resulting in the use of PRN medication related to the individual's behavior.
  - A description of the steps that were taken prior to the use of the PRN medication to avoid the use of a PRN medication related to the individual's behavior.

- If a PRN medication was used before a medical or dental appointment, a description of the desensitization plan in place to lessen the need for a PRN medication for a medical or dental appointment.
- The criteria the provider has in place for use of a PRN medication related to an individual's behavior.
- A description of the provider's PRN medication protocol related to an individual's behavior, including the provider's:
  - notification process regarding the use of a PRN medication related to an individual's behavior, and
  - approval process for the use of a PRN medication related to an individual's behavior.
- The name and title of the staff approving the use of the PRN medication related to the individual's behavior.
- The medication and dosage that was approved for the PRN medication related to the individual's behavior.
- The date and time of any previous PRN medication given to the individual related to the individual's behavior based on current records.

For the full incident reporting policy refer to <http://www.in.gov/fssa/servicedisabl/bqis.html>

Providers can be referred to the local BDDS office for appropriate follow up as well as being referred to BQIS as a complaint and/or to sanctions due to non-compliance.

BQIS is responsible for the implementation of a mortality review process for all individuals receiving services under waivers administered by BDDS. All deaths meeting the following criteria will be reviewed by the full Mortality Review Committee (MRC):

- Deaths due to alleged, suspected, or known abuse, neglect or exploitation;
- Deaths from trauma/accident (fall, drowning, vehicular, unexplained injury, etc.);
- Deaths required to be reported to the coroner or medical examiner [IC 36-2-14-6(a)];
- Suspected, alleged, or known homicide or suicide;
- Deaths due to sepsis, aspiration, choking, pneumonia, seizures, bowel obstruction;
- Deaths possibly due to lack of appropriate non-emergency medical treatment that directly contributed to the death (medication errors, lack of supervision or training, repeated occurrences such as falls that place an individual at risk without intervention, improper feeding/positioning of individual with known aspiration risk, etc.);
- Deaths possibly due to lack of appropriate response or delayed response by provider staff, emergency personnel, or a personal emergency response system (such as, lack of timely assessment of injuries, failure to recognize an emergency situation exists, care given at a lesser level than the average citizen would receive, and so forth); and
- Deaths due to elopement.

Cases not automatically requiring full MRC review may be resolved via the following means BQIS may:

- Close a case with no further action needed, or
- Refer a case to the Subcommittees.
- Subcommittees will review all cases that have been referred for consideration; then a Subcommittee may:

- Close a case that does not require full MRC review, with recommendations regarding the case, or
- Request additional information and review the case a second time when the requested information is in file; or
- Refer a case to the full MRC, with recommendations regarding the case;

The full MRC will review all cases that have been referred for consideration; then the MRC may:

- Request additional information and review the case a second time when the requested information is in file.
- Close a case with recommendations for the provider.
- Close a case with no recommendations.

Criteria for cases that may not necessarily be reviewed by the Subcommittees and/or the full MRC:

- Deaths of minor children or disabled adults who lived at home with their parents (unless abuse, neglect, or exploitation is alleged or suspected);
- Deaths due to a terminal illness when terminal illness is actual cause of death;
- Deaths due to natural causes, with the exceptions as described in the list of cases requiring full MRC review, as above.

In addition, 10 percent of the cases closed by BQIS will be randomly chosen each quarter and will be reviewed by the supervisor of the MRC coordinator or analyst to assure consistency and accuracy of the decisions. If needed, the supervisor will consult with one of the health care practitioners on the MRC.

Cases may be closed at this point or may be referred to the subcommittees if the issues of a case warrant further consideration. All deaths that meet the criteria below will be analyzed by BQIS, but may not necessarily be reviewed by the full MRC. BQIS will determine if issues exist (or are suspected) in these cases that rise to the level of significance as those automatically requiring full MRC review.

For the full MRC policy refer to <http://www.in.gov/fssa/servicedisabl/bqis.html>

BQIS also investigates complaints pertaining to any individual receiving services on a waiver administered by the BDDS. Complaints may be initiated by any individual. For the full Complaint policy refer to <http://www.in.gov/fssa/servicedisabl/bqis.html>

### **Waivers – Nursing Facility Level of Care**

The Division of Aging (DA) is responsible for monitoring the provider and case management standards for the waivers administered by DA as detailed in *460 IAC 1.2*. In addition, the DA is responsible for the implementation and monitoring of the incident reporting process as detailed in *460 IAC 1.2*. This rule is in place for provider surveys. Non-compliance with the standards may result in corrective action plans which are monitored by the DA. If a provider fails to complete a corrective action plan as required in the standards, sanctions may be imposed.

The DA is responsible for the implementation of a mortality review process for all individuals receiving services under waivers administered by the DA. All deaths meeting the following criteria will be reviewed by the full Mortality Review Committee (MRC):

- Deaths due to alleged, suspected, or known abuse, neglect or exploitation;
- Deaths from trauma/accident (fall, drowning, vehicular, unexplained injury, etc.);

- Deaths required to be reported to the coroner/medical examiner [IC 36-2-14-6(a)];
- Suspected, alleged, or known homicide or suicide;
- Deaths due to sepsis, aspiration, choking, pneumonia, seizures, bowel obstruction;
- Deaths possibly due to lack of appropriate non-emergency medical treatment that directly contributed to the death (medication errors, lack of supervision or training, repeated occurrences such as falls that place an individual at risk without intervention, improper feeding/positioning of individual with known aspiration risk, etc.);
- Deaths possibly due to lack of appropriate response or delayed response by provider staff, emergency personnel, or a personal emergency response system (i.e., lack of timely assessment of injuries, failure to recognize an emergency situation exists, care given at a lesser level than the average citizen would receive, etc.); and
- Deaths due to elopement.

Cases not automatically requiring full MRC review may be resolved via the following means:

- The DA may
  - Close a case, after initial review with no further action needed, or
  - Refer a case to the subcommittees.
- Subcommittees will review all cases that have been referred for consideration; then a subcommittee may:
  - Close a case that does not require full MRC review, with recommendations regarding the case, or
  - Request additional information and review the case a second time when the requested information is in file; or
  - Refer a case to the full MRC, with recommendations regarding the case.
- The full MRC will review all cases that have been referred for consideration; then the MRC may:
  - Request additional information and review the case a second time when the requested information is in the file.
  - Close a case with recommendations for further action.
  - Make a referral to another entity.
  - Close a case with no recommendations.
- Criteria for cases that may not necessarily be reviewed by the subcommittees and/or the full MRC, but which will receive an initial DA review include:
  - Deaths of minor children or disabled adults who lived at home with their parents (unless abuse, neglect, or exploitation is alleged or suspected);
  - Deaths due to a terminal illness when terminal illness is actual cause of death;
  - Deaths due to natural causes, with the exceptions as described in the list of cases requiring full MRC review, as above.
- In addition, 10 percent of the cases closed by the DA will be randomly chosen each quarter and will be reviewed by the supervisor of the MRC coordinator or analyst to assure consistency and accuracy of the decisions. If needed, the supervisor will consult with one of the health care practitioners on the MRC.
- Cases may be closed at this point or may be referred to the subcommittees if the issues of a case warrant further consideration. All deaths will be analyzed by the DA, but may not necessarily be reviewed by the full MRC. The DA will determine if issues exist (or are suspected) in these cases that rise to the level of significance as those automatically requiring full MRC review.

The DA uses the protocols outlined in the BQIS MRC policy. For the full MRC policy refer to <http://www.in.gov/fssa/servicedisabl/bqis.html>

The DA also investigates complaints pertaining to any individual receiving services on a waiver administered by the DA. Complaints may be initiated by any individual. The DA is utilizing the protocols outlined in the BQIS Complaint policy. For the full Complaint policy refer to <http://www.in.gov/fssa/servicedisabl/bqis.html>

## **Waiver Audits**

As part of its required oversight of the waiver program, the OMPP contracts with a Waiver Audit Team to conduct audits of waiver providers. This audit assists OMPP in meeting Federal assurances that funds are appropriately utilized, that members were eligible for the services provided, and that services were appropriately provided according to the Centers for Medicaid Services (CMS)-approved waivers.

## **FSSA Audit Oversight**

The Audit division of the FSSA reviews Waiver Audit Team schedules and findings to reduce redundancy and to assure use of consistent methodology.

## **Medicaid Fraud Control Audit Overview**

The Indiana Medicaid Fraud Control Unit (MFCU) is an investigative branch of the Attorney General's Office. MFCU conducts investigations in the following areas:

- Medicaid provider fraud
- Misuse of Medicaid members' funds
- Patient abuse or neglect in Medicaid facilities

When the MFCU identifies a provider who has violated one of these areas, the provider's case is presented to the state or federal prosecutors for appropriate action. Access information about MFCU at <http://www.in.gov/attorneygeneral/consumer/medicaidfraud.html>.

## Section 4: HCBS Waiver Types

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### Nursing Facility Level of Care Waivers

#### Overview

Indiana administers two home and community based waivers for persons who meet eligibility for nursing facility services: the Waiver for persons who are Aged and Disabled, and the Waiver for persons with a Traumatic Brain Injury. Per agreement with the State Medicaid Agency, the DA has responsibility for the day to day operations of these waivers, according to the approved waiver documents. The State Medicaid agency retains oversight authority.

#### Level of Care (LOC)

Persons who meet eligibility for these Medicaid Waivers must meet nursing facility *level of care*. The criteria necessary to meet this level of care is outlined in *405 IAC 1-3*. View the most up-to-date version of *405 IAC 1-3* in its entirety on the Internet at <http://www.in.gov/legislative/iac/title405.html>.

#### Waivers

##### Aged and Disabled Waiver (A&D)

The Aged and Disabled Waiver is designed to provide an alternative to nursing facility admission for Medicaid eligible persons over the age of 65, and persons of all ages with disabilities by providing supports to complement and supplement informal supports for persons who would require care in a nursing facility if waiver services were not available. Indiana's 16 Area Agencies on Aging act as the entry points for this waiver. The services available through this waiver are designed to assist participants to remain in their own homes and communities, as well as to assist individuals residing in nursing facilities to return to community settings, be it their own homes or other congregate community settings such as assisted living.

- Participant Eligibility
  - Individuals meeting Level of Care (LOC) and Medicaid eligibility requirements must also meet at least one of the following criteria in order to receive services through this Waiver: Age 65 and older, or disabled
- Medicaid aid category:
  - Aged (MAA), Blind (MAB), Low-income family (MAC), Disabled (MAD), Working Disabled (MADW)
- Services available: (Refer to *Sections 7 – 39* for service definitions)
  - Case management
  - Homemaker
  - Respite care
  - Adult day services
  - Environmental modifications
  - Transportation
  - Specialized medical equipment and supplies (including vehicle modifications)
  - Personal emergency response system



- Attendant care
- Adult foster care
- Assisted living
- Home delivered meals
- Nutritional supplements
- Pest control
- Community transition services

### **Traumatic Brain Injury Waiver (TBI)**

Medicaid eligible individuals of any age who have experienced an external insult resulting in a traumatic brain injury, and who require services ordinarily only available in a nursing facility, may receive services through this waiver. This waiver is designed to provide supports such as personal assistance, limited habilitation services, and respite care, as well as limited environmental modifications.

- Participant eligibility
  - Individuals meeting LOC and Medicaid eligibility requirements must also meet the following criteria in order to receive services through this Waiver: Aged (Age 65 and older) or disabled, and have experienced a traumatic brain injury.
- Medicaid aid category
  - Aged (MAA), Blind (MAB), Low-income family (MAC), Disabled (MAD), Working Disabled (MADW)
- Services available: (Refer to *Sections 7 – 39* for service definitions)
  - Case management
  - Homemaker
  - Respite care
  - Adult day services
  - Residential habilitation
  - Day Habilitation/Structured day program
  - Supported employment
  - Environmental modifications
  - Health care coordination
  - Transportation
  - Specialized medical equipment and supplies (including vehicle modifications)
  - Personal emergency response system
  - Attendant care
  - Occupational therapy
  - Physical therapy
  - Speech-Language therapy
  - Behavior management/behavior program and counseling

## **ICF/MR Level of Care Waivers**

### **Overview**

Indiana administers the following three waivers for persons with developmental disabilities:

- Waiver for Persons with Autism
- Waiver for Persons with Developmental Disabilities

- Support Services Waiver

Per agreement with the State Medicaid Agency, the Division of Disability and Rehabilitative Services is responsible for the day to day operations of these waivers according to the CMS approved waivers. The State Medicaid agency retains oversight authority.

## **Level of Care (LOC)**

Persons who meet eligibility for these Medicaid Waivers must meet ICF/MR “level of care”. The criteria necessary to meet this level of care is outlined in *405 IAC 1-3*. View the most up-to-date version of *405 IAC 1-3* in its entirety on the Internet at <http://www.in.gov/legislative/iac/title405.html>.

## **Waivers**

### **Developmental Disabilities Waiver (DD)**

The DD waiver serves persons with developmental disabilities who are Medicaid eligible to remain in their homes or in community settings, and assists those individuals who transition from state operated facilities or other institutions to community settings. This waiver is designed to provide support for individuals to gain and maintain optimum levels of self determinations and community integration while allowing flexibility in the provision of those supports.

- Participant Eligibility
  - Individuals meeting Level of Care and Medicaid eligibility requirements must also meet the following criteria in order to receive services through this Waiver: Developmentally Disabled per the Bureau of Developmental Disabilities Services (*IC 12-11-2.1-1*), Mentally Retarded and/or Developmentally Disabled.
- Medicaid aid category
  - Aged ( MAA), Blind (MAB), Low-income family (MAC), Disabled (MAD), Working Disabled (MADW)
- Services available: (Refer to *Sections 7 – 39* for service definitions)
  - Residential habilitation and support
  - Day services
  - Behavioral support services//crisis assistance
  - Adult foster care
  - Adult day services
  - Respite care
  - Physical therapy
  - Speech-Language therapy
  - Occupational therapy
  - Therapy services (psychological therapy)
  - Music therapy
  - Recreational therapy
  - Rent and food for unrelated live-in caregiver
  - Personal emergency response system
  - Community transition services
  - Family and caregiver training
  - Environmental modifications
  - Specialized medical equipment and supplies (including vehicle modifications)

## Autism (AU)

The Waiver for Persons with Autism provides community supports to individuals with Autism, including Autism Spectrum Disorder, who meet eligibility requirements. The waiver is designed to provide services for individuals living with family, or in other community settings for individuals to gain and maintain optimum levels of self determinations and community integration while allowing flexibility in the provision of those supports.

- Participant eligibility
  - Individuals meeting Level of Care and Medicaid eligibility requirements must also meet the following criteria in order to receive services through this Waiver: Developmentally Disabled per the Bureau of Developmental Disabilities Services (IC 12-11-2.1-1), Diagnosis of Autism Spectrum Disorder (Autism, Asperger's syndrome, or Other Pervasive Developmental Disorders)
- Medicaid aid category
  - Aged ( MAA), Blind (MAB), Low-income family (MAC), Disabled (MAD), Working Disabled (MADW)
- Services available: (Refer to *Sections 7 – 39* or service definitions)
  - Residential habilitation and support
  - Day services
  - Behavioral support services and crisis assistance
  - Adult foster care
  - Adult day services
  - Respite care
  - Physical therapy
  - Speech-Language therapy
  - Occupational therapy
  - Therapy services (psychological therapy)
  - Music therapy
  - Recreational therapy
  - Rent and food for unrelated live-in caregiver
  - Personal emergency response system
  - Community transition services
  - Family and caregiver training
  - Environmental modification
  - Specialized medical equipment and supplies (including vehicle modifications)
  - Applied behavior analysis

## Support Services Waiver (SSW)

The Support Services Waiver is designed to provide supports to persons with developmental disabilities residing with their families, or in other settings with informal supports.

- Participant eligibility
  - Individuals meeting Level of Care and Medicaid eligibility requirements must also meet the following criteria in order to receive services through this Waiver: Developmentally Disabled per the Bureau of Developmental Disabilities Services (IC 12-11-2.1-1), Mentally Retarded and/or Developmentally Disabled.
- Medicaid aid category
  - Aged ( MAA), Blind (MAB), Low-income family (MAC), Disabled (MAD), Working Disabled (MADW)

- Services available: (Refer to *Sections 7 – 39* for service definitions)
  - Day services
  - Behavioral support services/crisis assistance
  - Adult day services
  - Respite care
  - Physical therapy
  - Speech-Language therapy
  - Occupational therapy
  - Therapy services (psychological therapy)
  - Music therapy
  - Recreational therapy
  - Personal emergency response system
  - Family and caregiver training
  - Specialized medical equipment and supplies (including vehicle modifications)

## Section 5: Case Management

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### For Nursing Facility LOC Waivers

Medicaid waiver ongoing case managers coordinate and integrate all services required in a client's plan of care, link clients to needed services, and ensure that clients continue to receive and benefit from services. Waiver case managers enable clients to receive a full range of services needed because of a medical condition, in a planned, coordinated, efficient, effective manner.

Case management is a comprehensive service comprised of specific tasks and activities designed to coordinate and integrate all other services required in the client's plan of care. Case management is required in conjunction with the provision of any home and community-based service (HCBS).

The components of case management are:

- Level of care assessment
- Ongoing coordination with local Division of Family Resources (DFR) regarding Medicaid eligibility status
- Plan of care development
- Monitoring

Case Management services for persons who are on nursing facility Medicaid waivers are provided by the Division on Aging (DA) certified case managers. The 16 local Area Agencies on Aging (AAA) serve as the single point of entry for the nursing facility Medicaid waivers. A case manager from the AAA will be assigned to an applicant. After an applicant has been determined to meet the eligibility criteria and approved to receive nursing facility Medicaid waiver services, he or she may choose to retain their current AAA case manager or choose a non-AAA or independent case manager, for on-going case management services.

Minimum qualifications for individual case managers:

- All case management services provided must comply with the Case Management Standards
- The minimum educational/experience criteria for providing this service under the A&D Waiver are:
  - Bachelor's Degree in Social Work, Psychology, Sociology, Counseling, Gerontology, or Nursing; OR
  - Registered Nurse with one year experience in human services; OR
  - Bachelor's Degree in any other field with a minimum of two years full-time, direct service experience with the elderly or persons with disabilities. This experience must include assessment, care plan development, and monitoring; OR
  - Master's Degree in a related field may substitute for the required experience
- The minimum educational/experience criteria for providing this service under the TBI Waiver are:
  - A qualified Mental Retardation Professional (QMRP) who meets the QMRP requirements listed under 42 CFR483.430; OR
  - Registered Nurse with one (1) year experience in human services; OR
  - A Bachelor's Degree in any field with a minimum of one (1) year full-time, direct service experience with individuals with TBI or developmental disability. This experience includes assessment, care plan development, and monitoring

- All Case managers must attend Indiana Family and Social Services (FSSA) *Case Management Orientation* within the first six months of employment. Until a case manager has successfully completed the orientation, he or she may not work independently.
- All case managers must annually obtain at least 20 hours of training regarding case management services. Ten hours of this training must be training approved by DDRS under the nursing facility waiver program.

If the DA identifies a systemic problem with a case management provider's services, the provider shall obtain training on the topics recommended by the DA

Case management may not be conducted by:

- Any organization, entity, or individual that also delivers other in-home and community-based services under the nursing facility waiver program, or
- Any organization, entity, or individual related by common ownership or control to any other organization, entity, or individual who also delivers other in-home and community-based services under the nursing facility waiver program, unless the organization is an AAA that has been granted permission by the Family and Social Services Administration to provide direct services to clients.
  - *Common Ownership* exists when an individual, individuals, or any legal entity possess ownership or equity of at least five percent in the provider as well as the institution or organization serving the provider. *Control* exists where an individual or organization has the power or the ability, directly or indirectly, to influence or direct the actions or policies of an organization or institution, whether or not actually exercised.
  - *Related* means associated or affiliated with, or having the ability to control, or be controlled by.

Reimbursement of case management services, defined herein, may not be made unless and until the client becomes eligible for waiver service. Case management service provided to individuals who are not eligible for Medicaid waiver services will not be reimbursed as a waiver service.

### **Case Management Monitoring Standards**

The *On-going Medicaid Home and Community Based Services Waiver Case Management Standards* is the document that delineates the standards each nursing facility waiver case manager must meet in order to fulfill the FSSA DA guiding principles of responsive, efficient, effective, quality, and timely service delivery; effective communication; respect, dignity, integrity, and rights for all individuals; person-centered planning, informed choice, and personal empowerment; community-based services; fiscal stewardship; and quality customer services.

Case managers are to comply with all applicable DA standards. The following is excerpted from the *Case Management Medicaid Waiver Provider Agreement*.

### **On-Going Medicaid Home and Community Based Services Waiver Case Management Standards**

1. Case managers will maintain the highest professional and ethical standards in the conduct of their business.
2. Case managers will comply with all DA issued manuals, as well as all federal, state, and local law, and all FSSA policy, rules, regulations and guidelines.
3. New case managers will complete case manager orientation as approved by FSSA, prior to being eligible for Medicaid reimbursement.
4. Case managers will maintain competency by completing 20 hours of DDRS approved training in each calendar year. The training will include 10 hours of DDRS approved core training and 10 hours of related training per calendar year. This is in addition to new case manager orientation.

5. Individuals will choose their service provider, including case manager, and shall have the right to change any provider, including case manager.
6. Case managers will provide to individuals a list of potential providers, furnished by the State of Indiana, including case managers and the services offered by each provider.
7. Case managers will provide, at a minimum but not limited to, a state information guide to individuals on how to choose a provider and will assist the individual to evaluate potential service providers.
8. A maximum response time between implementation of the initial plan of care and the first monitoring contact will be no more than 30 calendar days.
9. Case managers will have face to face contact with each individual a minimum of every ninety (90) days to assess the quality and effectiveness of the plan of care. At least two of these face to face contacts per year will be in the home setting.
10. Case managers will document, in the chronological narrative, each contact with the individual and each contact with providers every 90 days, at a minimum.
11. Case managers will facilitate and monitor the formal and informal supports that are developed to maintain the individual's health and welfare in the community.
12. Case managers will provide each individual/guardian with clear and easy instructions for contacting the case manager or case manager agency. The case manager will also provide additional information and procedures for individuals who may need assistance or have an emergency that occurs before or after business hours. This information will be located in the home in a location that is visible from the telephone.
13. Case managers will complete annual assessments and care plan updates, in collaboration with the individual, in a timely and appropriate manner to avoid gaps in service .authorization, including assuring that the individual/guardian receives instructions on how to request an appeal through the Medicaid Fair Hearing process.
14. Case managers will communicate the individual's needs, strengths and preferences to the support team.
15. Case managers will assure that "person centered planning" is occurring on an ongoing basis.
16. Case managers will monitor the ongoing services to assure that they reflect the "person centered planning" and the care plan, including the individual's medication regime.
17. Case managers will base the plan of care upon the individual's needs, strengths, and preferences.
18. Case managers will facilitate the development of the support team and call meetings as needed.
19. Case managers will assure that the individual and all providers have a current, comprehensive plan of care that meets program fiscal parameters, on which services are based.
20. Case managers will review and explain to the individual/guardian the services that will be provided, and the individual will sign the plan of care to show understanding of and agreement with the plan.
21. Case Managers will assure that the individual/guardian, providers and involved agencies have a copy of relevant documentation, as specified in the Waiver Case Management Manual, including instructions on how tot request an appeal.
22. Case Managers will obtain all required signatures on the plan of care before submitting it to the State via the Area Agency on Aging. Any plan of care requiring State approval will not be implemented prior to obtaining State approval.
23. Case managers will document the quality, timeliness and appropriateness of care, services and products as delivered by providers, including an assessment of the appropriateness and achievement of goals as stated in the plan of care.

24. Case managers will initiate timely follow up of identified problems, whether self identified or referred by others. Critical/crisis issues will be acted on immediately, as specified by the DA. All follow-up and resolution will be documented in the individual record.
25. Case managers will comply with all automation standards and requirements as prescribed by the DA for documentation and processing of case management activities.
26. Case managers will keep all files in a standardized format and sequence.
27. Case managers will maintain privacy and confidentiality of all individual records. No information will be released/shared with others without the individual/guardian's written consent.
28. Case managers will provide to the State upon request, ready access to all case manager documentation, either electronic or hard copy.
29. Case manager documentation will demonstrate that the safety and welfare of the individual is being monitored on a regular basis.

## For ICF/MR LOC Waivers

For individuals receiving services under the Autism, Developmental Disabilities or Support Services Waivers, Case Management is a Medicaid Administrative service and *not* a Medicaid Waiver service.

Case Management is a comprehensive service comprised of a variety of specific tasks and activities designed to coordinate and integrate all other services required in the individual's care plan. Case Management is required in conjunction with the provision of any home and community –based service. *Services*, as referred to hereafter in this section, means case management services that enable an individual to receive a full range of appropriate services in a planned, coordinated, efficient, and effective manner.

### A. Required Activities.

1. Monitoring of services as outlined in *460 IAC 6*.
2. Face-to-face contacts between the case manager and individual in accordance with *460 IAC 6*.
3. Facilitation and coordination of the PCP process to be done by case manager in conjunction with the Individual, the Individual's legal representative, or any other team member (s). The PCP Process must:
  - (a) Take into account the Individuals' means of learning, decision-making processes, and desire to be productive.
  - (b) Document the Individual's likes and dislikes
4. Developing, updating, and reviewing ISP using the PCP process to empower the Individual and the individual's family to create a life plan for that Individual that:
  - (a) Is based on the Individual's preference, desires, and needs.
  - (b) Encourages and supports the Individual's long term hopes and desires.
  - (c) Is supported by a short term plan that is based on approved costs, given the Individual's support needs.
  - (d) Includes Individual responsibility.
  - (e) Includes a range of supports, including waiver, community, and natural.
5. Facilitating completion of the annual waiver requirements including:
  - (a) Level of Care re-determination
  - (b) Annual review and update of the PCP and ISP
  - (c) Annual submission of the waiver budget



6. Developing annual Cost Comparison Budgets using State-approved processes.
7. Disseminating information and forms to the Individual and the Individualized Support Team (IST).
8. Incident report completion, submission, and follow-up using

*B. Case Management Qualifications.*

*Minimum Qualifications* – All case managers providing services must comply with one or more of the qualifications set forth below:

1. Holding a bachelor's degree in one of the following specialties from an accredited college or university:
  - (a) Social work
  - (b) Psychology
  - (c) Sociology
  - (d) Counseling
  - (e) Gerontology
  - (f) Nursing
  - (g) Special education
  - (h) Rehabilitation
  - (i) or related degree if approved by DDRS/OMPP representative
- 2.. A registered nurse with one (1) year experience in human services.
3. A bachelor's degree in any field with a minimum of one (1) year full-time, direct experience working with persons with developmental disabilities.
4. A master's degree in a related field may substitute for required experience.

## Section 6: Service Definitions

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### Service Definition Overview

Section 7 through Section 39 of this manual list each individual service definition currently approved for the Home and Community Based Wavier Services (HCBS) Waiver program. Each section identifies a service definition and includes the following information:

- A rate table that identifies procedure codes and modifiers, the waivers that the service is available for, and the payment methodology associated with the procedure code. Please note that the DA, DDRS, OMPP and the Fiscal Agent are in the process of reviewing procedure codes and modifiers. The appropriate information databases and this manual will be revised to reflect any changes/updates.
- A definition of the service.
- A list of allowable activities for the service.
- A list of activities not allowed
- Service standards
- Documentation standards
- A licensure and certification table that identifies the waiver, the license or certification requirements, and any additional standards that apply.

**The following is the list of the service definition titles by the section number in which they appear:**

- |   |  |
|---|--|
| 7. Adult Day Services                               | 24. Music Therapy  |
| 8. Adult Foster Care                                | 25. Nutritional Supplements  |
| 9. Applied Behavior Analysis Services               | 26. Occupational Therapy Services  |
| 10. Assisted Living Services                        | 27. Personal Emergency Response system Supports (PERS)                           |
| 11. Attendant Care Services                         | 28. Pest Control   |
| 12. Behavior Management/Behavior Program Counseling | 29. Physical Therapy Services  |
| 13. Behavioral Support Services/Crisis Assist.      | 30. Recreational Therapy Services  |
| 14. Case Management ICF/MR LOC Waivers              | 31. Rent and Food for Unrelated Live-in Caregiver Supports                       |
| 15. Case Management Nursing Facility LOC Waivers    | 32. Residential Habilitation [Nursing Facility LOC]                              |
| 16. Community Transition Services                   | 33. Residential Habilitation and Support Services (ICF/MR LOC)                   |
| 17. Day Habilitation/Structured Day Program         | 34. Respite Care Services  |
| 18. Day Services                                    | 35. Specialized Medical Equipment and Supplies (including vehicle modifications) |
| 19. Environmental Modifications                     | 36. Speech/Language Therapy  |
| 20. Family and Caregiver Training Services          | 37. Supported Employment   |
| 21. Health Care Coordination Services               | 38. Therapy Services – Psychological   |
| 22. Home Delivered Meals                            |  |
| 23. Homemaker Services                              |  |

39. Transportation

## Section 7: Adult Day Services

Table 7.1 – Description of Billing and Reimbursement for Adult Day Services

Procedure Code and Modifier	INsite Code	Procedure Code Description	Reimbursement/Unit Measurement Methodology	Waivers
S5101 U7 U1	ADS1	Adult Day Services, Level 1, per half day	Based on an approved NOA Half day rate	AD, AU, DD, SSW, TBI
S5101 U7 U2	ADS2	Adult Day Services, Level 2, per half day	Based on an approved NOA Half day rate	AD, AU, DD, SSW, TBI
S5101 U7 U3	ADS3	Adult Day Services, Level 3, per half day	Based on an approved NOA Half day rate	AD, AU, DD, SSW, TBI
S5100 U7 U1	AS14	Adult Day Services, Level 1, per 15 minutes	Based on an approved NOA One unit = 15 minutes One hour = 4 units	AD, AU, DD, SSW, TBI
S5100 U7 U2	AS24	Adult Day Services, Level 2, per 15 minutes	Based on an approved NOA One unit = 15 minutes One hour = 4 units	AD, AU, DD, SSW, TBI
S5100 U7 U3	AS34	Adult Day Services, Level 3, per 15 minutes	Based on an approved NOA One unit = 15 minutes One hour = 4 units	AD, AU, DD, SSW, TBI

### Service Definition

Adult Day Services are community-based group programs designed to meet the needs of adults with impairments through individual plans of care. These structured, comprehensive, non-residential programs provide health, social, recreational, and therapeutic activities, supervision, support services, and personal care. Meals and/or nutritious snacks are required. The meals cannot constitute the full daily nutritional regimen. However, each meal must meet 1/3 of the daily Recommended Dietary Allowance. These services must be provided in a congregate, protective setting.

Individuals attend Adult Day Services on a planned basis. A minimum of 3 hours to a maximum of 12 hours shall be allowable. The three levels of Adult Day Services are Basic, Enhanced, and Intensive.

A ½ day unit is defined as one unit of three hours to a maximum five hours/day. Two units is more than five hours to a maximum of eight hours/day. Maximum two units/day.

A ¼ hour unit is defined as 15 minutes. Billable only after eight hours of ADS service have been provided on the same day. Maximum 16 units/day.

### Allowable Activities

#### Basic Adult Day Services (Level 1) includes:

- Monitor and/or supervise all activities of daily living (ADLs) defined as dressing, bathing, grooming, eating, walking, and toileting with hands-on assistance provided as needed.
- Comprehensive, therapeutic activities.
- Health assessment and intermittent monitoring of health status.

- Monitor medication or medication administration.
- Appropriate structure and supervision for those with mild cognitive impairment.
- Minimum staff ratio: One staff for each eight individuals.

**Enhanced Adult Day Services (Level 2) includes:**

Level 1 service requirements must be met. Additional services include:

- Hands-on assistance with two or more ADLs or hands-on assistance with bathing or other personal care.
- Health assessment with regular monitoring or intervention with health status.
- Dispense or supervise the dispensing of medication to individuals.
- Psychosocial needs assessed and addressed, including counseling as needed for individuals and caregivers.
- Therapeutic structure, supervision, and intervention for those with mild to moderate cognitive impairments.
- Minimum staff ratio: One staff for each six individuals.

**Intensive Adult Day Services (Level 3) includes:**

Level 1 and Level 2 service requirements must be met. Additional services include:

- Hands-on assistance or supervision with all ADLs and personal care.
- One or more direct health intervention(s) required.
- Rehabilitation and restorative services, including physical therapy, speech therapy, and occupational therapy coordinated or available.
- Therapeutic intervention to address dynamic psychosocial needs such as depression or family issues affecting care.
- Therapeutic interventions for those with moderate to severe cognitive impairments.
- Minimum staff ratio: One staff for each four individuals.

**Activities Not Allowed**

- Any activity that is not described in allowable activities is not included in this service.

**Service Standards**

- Adult Day Services must follow a written Plan of Care addressing specific needs determined by the client's assessment.

**Documentation Standards**

- Services outlined in the POC/CCB.
- Evidence that level of service provided is required by the individual.
- Attendance record documenting the date of service and the number of units of service delivered that day.

- Completed Adult Day Service Level of Service Evaluation form.

Case manager should give the completed Adult Day Service Level of Service Evaluation to the provider.

Table 7.2 – Provider Licensure and Certification Table for Adult Day Services

Waiver	Provider	License	Certification	Other Standard
AD, TBI	Qualified adult day service provider		Must comply with Indiana Medicaid Adult day Service Standards and Guidelines  Qualifications outlined in the Provider Application for Certification for Nursing Facility Waivers.	Must comply with the <i>Indiana Medicaid Adult Day Service Standards and Guidelines</i>  DA-approved 460 IAC 1.2-6-2 General requirements, 460 IAC 1.2-6-3 General requirements for direct care staff, 460 IAC 1.2-13 Professional qualifications and requirements, 460 IAC 1.2-14 Personnel Records, DA approval requirements
DD, AU, SSW	Adult day service agency – types: DDRS-approved adult day service facilities	Qualifications are outlined in 460 IAC 6		DDRS-approved, 460 IAC 6-10-5 Criminal Histories, 460 IAC 6-12 Insurance, 460 IAC 6-11 Financial Status of Providers, 460 IAC 6-5-2 Qualification for ADS, 460 IAC 6-14-5 Direct Care Staff Qualifications, 460 IAC 6-14-4 Staff Training, 460 IAC 6-5-30(b) Transportation requirements. Must comply with <i>BDDS Adult Day Service Standards and Guidelines</i>

## Section 8: Adult Foster Care

Table 8.1 – Description of Billing and Reimbursement for Adult Foster Care

Procedure Code and Modifier	INsite Code	Procedure Code Description	Reimbursement/Unit Measurement Methodology	Waivers
S5141 U7 U1	AF1	Foster Care, adult, per diem, Level 1	Based on an approved NOA Daily reimbursement rate	AD
S5141 U7 U2	AF2	Foster Care, adult, per diem, Level 2	Based on an approved NOA Daily reimbursement rate	AD
S5141 U7 U3	AF3	Foster Care, adult, per diem, Level 3	Based on an approved NOA Daily reimbursement rate	AD
S5141 U7 U1	AF1	Foster Care, adult, per diem, Waiver, Level 1	Based on an approved NOA Daily reimbursement rate	AU, DD
S5141 U7 U2	AF2	Foster Care, adult, per diem, Waiver, Level 2	Based on an approved NOA Daily reimbursement rate	AU, DD
S5141 U7 U3	AF3	Foster Care, adult, per diem, Waiver, Level 3	Based on an approved NOA Daily reimbursement rate	AU, DD

### Definition of Service

Adult Foster Care Services means a living arrangement in which an individual lives in the private home of a principal caregiver who is unrelated to the individual.

Necessary support services are provided by the principal caregiver (for example, a foster parent) as part of Adult Foster Care Services. For those providing services under the ICF/MR Level of care Medicaid waivers, only agencies may be foster care providers, with the foster care settings being certified, supervised, trained, and paid by the approved agency provider. For those providing services under the NF level of care Medicaid waivers, non-agency may also be foster care providers.

**Separate payment will not be made for homemaker or chore services furnished to an individual receiving Adult Foster Care Services, since these services are integral to and inherent in the provision of adult foster care services.**

For individuals receiving services under the A&D Waiver, the total number of individuals living in the home who are unrelated to the caregiver may not exceed three (3).

For individuals receiving services under the Autism or DD Waivers, an individual in level 1 may reside with a family and up to three (3) other individuals (no more than four (4) total), an individual in level 2 may not reside with more than 1 other individual. An individual in level 3 may not reside with any other individuals in the AFC program.

### Rate Levels

There are three levels of rates. For individuals receiving services on the Autism and DD Waivers, the Individualized Support Team (IST) determines what level of supports are required for the individual, based on what services an individual would utilize if foster care services were not available. For individuals receiving services on the A&D Waiver, the level of supports needed is determined by the Adult Foster Care level of service tool.

For the DD and Autism Waivers, a Service Planner must be completed showing the services and amounts of services required in another setting. If there are changes in the individual's condition that may call for a change in the level of service, the IST will re-determine what level of supports the individual requires, with ultimate approval given according to who can approve a specific level of service.

- Level 1 – Approved by Service Coordinator
- Level 2 – Approved by District Manager
- Level 3 – Approved by Central Office

Issues to consider in determining which tier of services the individual receives include the amount of time the foster family will need to spend in 1) health and safety management; 2) challenges and experiences aimed at increasing a person's ability to live a lifestyle that is compatible with the person's interest and abilities; 3) modification or improvement of functional skills; 4) guidance and direction for social/emotional support; and 5) facilitation of both the physical and social integration of a person into typical family routines and rhythms.

### **Allowable Activities**

- Personal care and services
- Homemaker or chore services
- Attendant care and companion care services
- Medication oversight
- Respite for the foster parent (**funding for this respite is included in the per diem paid to the service provider, the actual service of Respite Care may not be billed in addition to the per diem**)
- Other appropriate supports as described in the Individualized Support Plan

### **Activities Not Allowed**

- Services provided in the home of a caregiver who is related by blood or marriage, in any degree, to the individual

#### **DD, AU**

- The service of Residential Habilitation and Supports is not available to individuals receiving the service of Adult Foster Care
- Residential Living Allowance and Management Services are not available to individuals receiving Adult Foster Care

### **Service Standards – ICF/MR LOC Waivers**

- Adult Foster Care Services must be reflected in the Individualized Support Plan
- Services must address the needs (for example, developmental needs, vocational needs, and so forth) identified in the person centered planning process and be outlined in the Individualized Support Plan
- 10% of the total per diem amount is intended for use by the provider for respite care as needed. It is the provider's responsibility to approve any providers of respite chosen by the family or the individual



- The provider determines the total amount per month paid to the foster parent
- The agency's administrative/supervision fee comes from the remaining total amount and includes the following duties:
  - Publish written policies and procedures regarding foster parent support services
  - Maintain financial and service records to document services provided to the individual
  - Establish a criteria for the acceptance of the foster parent, screen potential foster parents for qualities of stability, maturity, and experiences so as to ensure the safety and well being of the individual, and obtain a criminal background and reference check
  - Coordinate/provide adequate initial training and ongoing training, consultation and supervision to the foster parent
  - Provide for the safety and well being of the individual by inspection of environment for compliance with DDRS policies and procedures, including, but not limited to, the provider and case management standards found in 460 IAC 6
  - Reimburse foster parent

### **Service Standards – NF LOC Waivers**

- Adult Foster Care services must follow a written Plan of Care addressing specific needs determined by the individual's assessment
- Adult Foster Care is provided in a private home for up to three (3) individuals, who are unrelated to the primary caregiver. Each individual has their own bedroom, access to a semi-private bathroom, and a common living area
- Adult Foster Care is a 24-hour care service and therefore, the AFC home shall consist of a ratio of at least one primary caregiver to a maximum of three (3) individuals at all times

### **Documentation Standards – DD and AU Waivers**

Adult Foster Care Services documentation must include the services outlined in the Individualized Support Plan.

#### **Documentation by Providers:**

- Written policies and procedures, including for screening and accepting foster parents.
- Maintain financial and service records to document services provided to the individual.
- Document provision of training to foster parents according to agency policies/procedures.
- Reimbursement of foster parent.
- One entry per individual per week (same as families).

#### **Documentation by Families:**

- One dated entry per day detailing an issue concerning the individual
- The entry should detail any outcome-oriented activities, tying those into measurable progress toward the individual's outcome (as identified in the ISP)
- The entry should also include any significant issues concerning the individual, including:
  - Health and safety management
  - Developmental challenges and experiences aimed at increasing an individual's ability to live a lifestyle that is compatible with the individual's interest and abilities
  - Modification or improvement of functional skills
  - Guidance and direction for social/emotional support

- Facilitation of both the physical and social integration of an individual into typical family routines and rhythms

### **Documentation Standards – A&D Waiver**

- Services outlined in the Plan of Care/ Cost Comparison Budget (POC/CCB)
- Completion of the Adult Foster Care Assessment Tool
- Evidence that the individual requires the level of service provided
- Documentation of support services rendered
- Case manager should give the completed Adult Foster Care Level of Service Evaluation to the provider
- Case Manager Checklist for On-Site Visits to the Adult Foster Care home

Table 8.2 – Provider Licensure and Certification Table for Adult Foster Care

<b>Waiver</b>	<b>Provider</b>	<b>License</b>	<b>Certification</b>	<b>Other Standard</b>
DD, AU	Agency – types: DDRS-approved AFC agencies			DDRS-approved, 460 IAC 6-10-5 <i>Criminal Histories</i> , 460 IAC 6-12 <i>Insurance</i> , 460 IAC 6-11 <i>Financial Status of Provider</i> , 460 IAC 6-5-3 <i>Adult Foster Care Qualifications</i> , 460 IAC 6-14-5 <i>Direct Care Staff Qualifications</i> , 460 IAC 6-14-4 <i>Staff Training</i> , DDRS-approval requirements
AD	Qualified agencies Individual providers			DA-approved 460 IAC 1.2-6-2 <i>General requirements</i> , 460 IAC 1.2-6-3 <i>General requirements for direct care staff</i> , 460 IAC 1.2-13 <i>Professional qualifications and requirements</i> , 460 IAC 1.2-14 <i>Personnel Records</i> , DA approval requirements  Must comply with <i>Adult Foster Care Standards and Guidelines</i>

## Section 9: Applied Behavior Analysis Services

Table 9.1 – Description of Billing and Reimbursement for Applied Behavior Analysis Services

Procedure Code and Modifier	INsite Code	Procedure Code Description	Reimbursement/Unit Measurement Methodology	Waivers
N/A		Procedure code not assigned at this time.		

### Service Definition

Applied Behavior Analysis Services (ABA) means a therapy service that is a highly intensive, individualized instruction and behavior intervention to assist an individual in developing skills with social value. Applied Behavior Analysis is provided over a two to three year time period and is provided to individuals between the ages of two and seven.

A key component of Applied Behavior Analysis is *discrete trial therapy*, which seeks to use empirically validated behavior change procedures for assisting individuals in developing skills with social value. The primary goals of ABA are to lessen behavioral excesses such as tantrum and acting out behaviors and to improve communication skills.

### Allowable Activities

- Preparing the applied behavior support plan in accordance with 460 IAC 6-18-1
- Discrete trial therapy consisting of:
  - *Antecedent*: A directive or request for the individual to perform an action
  - *Behavior*: A response from the individual, including anything from successful performance, non-compliance, or no response
  - *Consequence*: A reaction from the therapist, including a range of responses from strong positive reinforcement, faint praise, or a negative (not aversive) reaction
  - *Intertrial Interval*: A pause to separate trials from each other. Provide a minimum of four to six hours of services five to seven days a week for a for a period of two to three years
- Skills that are prerequisites to language are heavily emphasized (attention, cooperation, imitation)
- Provide for one-on-one structured therapy
- Specific program must include:
  - Attending skills (to therapist, adults and peers)
  - Imitation skills (motor and verbal)
  - Receptive and expressive language skills development
  - Appropriate toy play; and appropriate social interaction
  - Family training so that skills can be generalized and communication promoted
  - Emphasize the acquisition of new behaviors
  - Close monitoring of therapy, with detailed data collection

### Activities Not Allowed

- Aversive techniques
- Applied behavior analysis for an individual older than seven years

### Service Standards

- Applied Behavior Analysis Services must be reflected in the Individualized Support Plan
- Services must address needs identified in the person centered planning process and be outlined in the Individualized Support Plan
- Services must be detailed in the applied behavior support plan
- Services are usually one-to-one, with the exception of time spent in family training
- **Chemical restraints and medications prescribed for use as needed (PRN) meant to retrain the individual shall be used with caution.** The use of these medications must be approved by the person centered planning team and the appropriate human rights committee. The efficacy of the plan must be reviewed regularly and adjusted as necessary.
- **The behavior specialist will provide a written report to pertinent parties at least quarterly.** *Pertinent parties* includes the individual, guardian, BDDS service coordinator, waiver case manager, all service providers, and other entities.

### Documentation Standards

- Services outlined in the ISP.
- Documentation in compliance with 460 IAC 6.

Table 9.2 – Provider Licensure and Certification Table for Applied Behavior Analysis Services

Waiver	Provider	License	Certification	Other Standard
AU	Psychologist Psychiatrist	Licensed under <i>IC 25-33</i> ; Licensed under <i>IC 25-22.5</i>		DDRS certification for senior therapist; line staff. Agencies approved under <i>IC 12-11-1.1</i> and any certification requirements outlined in 460 IAC 6.

## Section 10: Assisted Living Services

Table 10.1 – Description of Billing and Reimbursement for Assisted Living Services

Procedure Code and Modifier	INsite Code	Procedure Code Description	Reimbursement/Unit Measurement Methodology	Waivers
T2031 U7 U1	AL1	Assisted living, level 1, per diem	Based on an approved NOA Daily rate	AD
T2031 U7 U2	AL2	Assisted living, level 2, per diem	Based on an approved NOA Daily rate	AD
T2031 U7 U3	AL3	Assisted living, level 3, per diem	Based on an approved NOA Daily rate	AD

### Service Definition

Assisted living service is defined as personal care and services, homemaker, chore, attendant care and companion services, medication oversight (to the extent permitted under State law), therapeutic social and recreational programming, provided in a home-like environment in a residential facility which is licensed by the Indiana State Department of Health (ISDH)), in conjunction with residing in the facility. This service includes 24 hour on-site response staff to meet scheduled or unpredictable needs in a way that promotes maximum dignity and independence, and to provide supervision, safety and security. Other individuals or agencies may also furnish care directly, or under arrangement with the community care facility, but the care provided by these other entities supplements that provided by the community care facility and does not supplant it.

Personalized care is furnished to individuals who reside in their own living units (which may include dually occupied units when both occupants consent to the arrangement) which may or may not include kitchenette and/or living rooms and which contain bedrooms and toilet facilities. The individual has a right to privacy. Living units may be locked at the discretion of the individual, except when a physician or mental health professional has certified in writing that the individual is sufficiently impaired as to be a danger to self or others if given the opportunity to lock the door. (This requirement does not apply where it conflicts with fire code.) Each living unit is separate and distinct from each other. The facility must have a central dining room, living room or parlor, and common activity center(s) (which may also serve as living rooms or dining rooms). The individual retains the right to assume risk, tempered only by the individual's ability to assume responsibility for that risk. Care must be furnished in a way which fosters the independence of each individual to facilitate aging in place. Routines of care provision and service delivery must be individual-driven to the maximum extent possible, and treat each person with dignity and respect.

### Allowable Activities

The following are included in the daily per diem for Assisted Living Services:

- Attendant care
- Chores
- Companion services
- Homemaker
- Medication oversight (to the extent permitted under State law)

- Personal care and services
- Therapeutic social and recreational programming

### **Activities Not Allowed**

- The Assisted Living service per diem does not cover room and board expenses or environmental modifications.

### **Service Standards**

- Assisted Living services must follow a written Plan of Care (POC) addressing specific needs determined by the client's assessment.

### **Documentation Standards**

- Services outlined in the POC/CCB
- Evidence that individual requires the level of service provided
- Documentation to support service rendered
- Requires completed *Assisted Living Level of Service Evaluation* form.
- Case manager should give the completed *Assisted Living Level of Service Evaluation* form to the provider.

Table 10.2 – Provider Licensure and Certification Table for Assisted Living Services

Waiver	Provider	License	Certification	Other Standard
AD,	Qualified Assisted Living Facilities	IC 16-28-2 410 IAC 16.2-5 Residential Care Facility Licensure		DA-approved 460 IAC 1.2-6-2 General requirements, 460 IAC 1.2-6-3 General requirements for direct care staff, 460 IAC 1.2-13 Professional qualifications and requirements, 460 IAC 1.2-14 Personnel Records, DA approval requirements

## Section 11: Attendant Care Services

Table 11.1 – Description of Billing and Reimbursement for Attendant Care Services

Procedure Code and Modifier	INsite Code	Procedure Code Description	Reimbursement/Unit Measurement Methodology	Waivers
S5125 U7	ATTC	Attendant Care Services, per 15 minutes (for agency use)	Based on an approved NOA One unit = 15 minutes One hour = 4 units	AD, TBI
S5125 U7 UA	ATTC	Attendant Care Services, per 15 minutes (for non agency use)	Based on an approved NOA One unit = 15 minutes One hour = 4 units	AD, TBI

### Definition of Service

Attendant Care Services primarily involve *hands-on* assistance for older adults and persons with disabilities who have physical needs. These services are provided in order to allow older adults or persons with disabilities to remain in their own home and to carry out functions of daily living, self-care, and mobility.

### Allowable Activities

Homemaker activities that are essential to the individual's health care needs in order to prevent or postpone institutionalization when provided during the provision of other attendant care services.

Provides assistance with personal care which includes:

- Bathing, partial bathing
- Oral hygiene
- Hair care including clipping of hair
- Shaving
- Hand and foot care
- Intact skin care
- Application of cosmetics

Provides assistance with mobility which includes:

- Proper body mechanics
- Transfer between bed and chair
- Ambulation- not including assistive devices

Provides assistance with elimination which includes:

- Assists with bedpan, bedside commode, toilet
- Incontinent or involuntary care
- Emptying urine collection and colostomy bags

Provides assistance with nutrition which includes:

- Meal planning, preparation, clean-up

Provides assistance with safety which includes:

- Use of the principles of health and safety in relation to self and individual
- Identify and eliminate safety hazards
- Practice health protection and cleanliness by appropriate techniques of hand washing
- Waste disposal, and household tasks
- Reminds client to self-administer medications.
- Provides assistance with correspondence and bill paying.
- Escorts individuals to community activities that are therapeutic in nature or that assist with developing and maintaining natural supports.

### **Activities Not Allowed**

- Attendant care services will not be provided to medically unstable individuals as a substitute for care provided by a registered nurse, licensed practical nurse, licensed physician, or other health professional.
- Attendant care services provided to household members other than the individual client.
- Persons who are directing care on behalf of the individual through the self-directed care option may not provide Attendant Care services.
- Specifically excluded as paid caregivers are the parent of a minor child and the spouse of a recipient.

### **Service Standards**

- Attendant Care services must follow a written Plan of Care addressing specific needs determined by the client's assessment.

### **June 2004 Newsletter – Attendant Care versus Homemaker Clarification**

If direct care or supervision of care is not provided to the client and the documentation of services rendered for the units billed reflects homemaker duties, an entry must be made to indicate why the direct care was not provided for that day. If direct care or supervision of care is not provided for more than 30 days and the documentation of services rendered for the units billed reflects homemaker duties, the case manager must be contacted to amend the POC to a) add Homemaker Services and eliminate Attendant Care Services or b) reduce attendant care hours and replace with the appropriate number of hours of homemaker services.

### **Documentation Standards**

- Identified need in the POC/CCB.
- Data record of services provided, including date of service and number of units delivered.
- Each staff member providing direct care or supervision of care to the client makes at least one entry on each day of service, describing an issue or circumstance concerning the client.



- Documentation should include the complete date and time (in and out), and at least the last name and first initial of the staff person making the entry. If the person providing the service is required to be a professional, the title of the individual must also be included.

Table 11.2 – Provider Licensure and Certification Table for Attendant Care Services

Waiver	Provider	License	Certification	Other Standard
AD, TBI	Community Developmental Disabilities Agencies	IC-7-2-39	CARF	DA-approved 460 IAC 1.2-6-2 General requirements, 460 IAC 1.2-6-3 General requirements for direct care staff, 460 IAC 1.2-13 Professional qualifications and requirements, 460 IAC 1.2-14 Personnel Records, DA approval requirements
AD, TBI	Licensed Home Health Agencies	Licensed by the Indiana State Department of Health IC 16-27-1		Same as above
AD, TBI	Individuals Family members			Same as above

## **Section 12: Behavior Management/Behavior Program and Counseling**

Table 12.1 – Description of Billing and Reimbursement for Behavior Management/Behavior Program and Counseling

Procedure Code and Modifier	INsite Code	Procedure Code Description	Reimbursement/Unit Measurement Methodology	Waivers
H0004 U7 U1	BMAN	Behavioral health counseling and therapy, level 1, 15 minute units	Based on an approved NOA One unit = 15 minutes One hour = 4 units	TBI
H0004 U7 U2	BMAN	Behavioral health counseling and therapy, level 2, 15 minute units	Based on an approved NOA One unit = 15 minutes One hour = 4 units	TBI

### **Service Definition**

Behavior Management includes training, supervision, or assistance in appropriate expression of emotions and desires, compliance, assertiveness, acquisition of socially appropriate behaviors, and the reduction of inappropriate behaviors.

Behavior plans must be developed, monitored, and amended by a master's level Psychologist or a master's in Special Education, supervised by an individual with a Ph.D. in Behavioral Science. Individuals implementing behavioral services shall either be supervised by a master's level Behaviorist or a Qualified Mental Retardation Professional (QMRP).

### **Level 1 Clinician (After January 1, 2003):**

Effective January 1, 2003, **only** Health Service Providers in Psychology (HSPP) Behavior Management providers will be able to be certified to provide Level 1 Behavior Management services. HSPP is defined in *IC 25-33-1*. Certification is granted to an individual who:

- 1) has a doctoral degree in clinical psychology, counseling psychology, school psychology, or another applied health service area of psychology;
- 2) is licensed under this section, section 5.3, or section 9 of this chapter;
- 3) has at least two (2) years of experience in a supervised health service setting in which one (1) year of experience was obtained in an organized health service training program and in which at least one (1) year of experience was obtained after the individual received the individual's doctoral degree in psychology; and
- 4) complies with the continuing education requirements under IC 25-33-1-5.1

### **Level 1 Clinicians (Prior to January 1, 2003):**

A Doctoral level Psychologist with HSPP license in Indiana; or at least an MA level clinician with a degree in a behavioral science, Special Education, or Social Work with five years documented direct contact experience working specifically with the DD population inclusive of experience: devising, implementing and monitoring behavior support plans; supervision and training of others in the implementation of behavior plans; or

**Level 2 Clinicians (must be supervised by a Level 1 Clinician) have a master's degree in:**

1. clinical psychology, counseling psychology, school psychology, or another applied health service area of psychology;
2. special education;
3. social work;
4. or counseling;
  - be a licensed marriage and family therapist licensed under IC 25-23.6;
  - be a licensed clinical social worker under IC 25-23.6;
  - be a licensed mental health counselor under

**Allowable Activities**

- Observation of the individual and environment for purposes of development of a plan and to determine baseline
- Development of a behavioral support plan and subsequent revisions
- Training in assertiveness
- Training in stress reduction techniques
- Training in the acquisition of socially accepted behaviors
- Training staff, family members, roommates, and other appropriate individuals on the implementation of the behavior support plan
- Consultation with members
- Consultation with HSPP

**Activities Not Allowed**

- Aversive techniques
- Any techniques not approved by the individual's person centered planning team and the provider's human rights committee
- In the event that a Level 1 clinician performs Level 2 clinician activities, billing for Level 1 services is not allowed. In this situation billing for Level 2 services only is allowed

**Service Standards**

- Behavior Management/ Behavior Program and Counseling must be reflected in the Plan of Care/ Cost Comparison Budget.
- The behavior specialist will observe the individual in his/her own milieu and develop a specific plan to address identified issues.
- Any behavior supports techniques that limit the individual's human or civil rights must be approved by the person centered planning team and the provider's human rights committee. No aversive techniques may be used.
- Chemical restraints and medications prescribed for use as needed (PRN) meant to retrain the individual shall be used with caution. The use of these medications must be approved by the person centered planning team and the appropriate human rights committee.

- The efficacy of the plan must be reviewed not less than quarterly and adjusted as necessary.
- The behavior specialist will provide a written report to pertinent parties at least quarterly. “Pertinent parties” includes the individual, guardian, waiver case manager, all service providers, and other involved entities.

### **Documentation Standards**

- Identified need in the POC/CCB
- POC/CCB must have the identified level clinician
- Behavioral support plan
- Data record of clinician service documenting the date and time of service, and the number of units of service delivered that day with the service type.

Table 12.2 – Provider Licensure and Certification Table for Behavior Management/Behavior Program and Counseling

<b>Waiver</b>	<b>Provider</b>	<b>License</b>	<b>Certification</b>	<b>Other Standard</b>
TBI	Community Developmental Disabilities Agencies Individuals	IC 12-7-2-39 Master’s level behaviorist, QMRP, Certified Social Worker supervised by a Master’s level behaviorist	CARF	DA-approved 460 IAC 1.2-6-2 General requirements, 460 IAC 1.2-6-3 General requirements for direct care staff, 460 IAC 1.2-13 Professional qualifications and requirements, 460 IAC 1.2-14 Personnel Records, DA approval requirements

## **Section 13: Behavioral Support Services/Crisis Assistance**

Table 13.1 – Description of Billing and Reimbursement for Behavioral Support Services and Crisis Assistance

<b>Procedure Code and Modifier</b>	<b>INsite Code</b>	<b>Procedure Code Description</b>	<b>Reimbursement/Unit Measurement Methodology</b>	<b>Waivers</b>
T2034 U7	CRIS	Crisis Intervention, Waiver, per diem	Based on an approved NOA Daily rate	AU, DD, SSW
H0046 U7 U1	BMG1 1	Behavioral health counseling and therapy, level 1, monthly unit rate	Based on an approved NOA One unit = 1 monthly unit rate	AU, DD, SSW
H00466 U7	BMGT	Behavioral health counseling and therapy, level 2, monthly unit rate	Based on an approved NOA One unit = 1 monthly unit rate	AU, DD, SSW

### **Service Definition**

Behavioral Support Services means training, supervision, or assistance in appropriate expression of emotions and desires, compliance, assertiveness, acquisition of socially appropriate behaviors, and the reduction of inappropriate behaviors.

### **Allowable Activities**

- Reimbursable activities of Behavioral Support Services include:
- Observation of the individual and environment for purposes of development of a plan and to determine baseline
- Development of a behavioral support plan and subsequent revisions
- Obtain consensus of the Individualized Support Team that the behavioral support plan is feasible for implementation.
- Training in assertiveness
- Training in stress reduction techniques
- Training in the acquisition of socially accepted behaviors
- Training staff, family members, roommates, and other appropriate individuals on the implementation of the behavioral support plan
- Consultation with team members
- Consultation with Health Service Providers in Psychology (HSPP)

### **Activities Not Allowed**

- Aversive techniques – Any techniques not approved by the individual's person centered planning team and the provider's human rights committee.
- In the event that a Level 1 clinician performs, Level 2 clinician activities, billing for Level 1 services is not allowed. In this situation, billing for level 2 services only is allowed.

## Service Standards

- Behavioral Support Services must be reflected in the Individualized Support Plan
- Services must address needs identified in the person centered planning process and be outlined in the Individualized Support Plan
- The behavior supports specialist will observe the individual in his or her own milieu and develop a specific plan to address identified issues.
- The behavior supports specialist must assure that Residential Habilitation and Supports direct service staff are aware of and are active individuals in the development and implementation of the Behavioral Support Plan.
- The behavior plan will meet the requirements stated in *460 IAC 6-18-2*.
- The behavior supports provider will comply with all specific standards in *460 IAC 6-18*.
- Any behavior supports techniques that limit the individual's human or civil rights must be approved by the Individualized Support Team (IST) and the provider's human rights committee. **No aversive techniques may be used. Chemical restraints and medications prescribed for use as needed (PRN) meant to retrain the individual shall be used with caution.** The use of these medications must be approved by the Individualized Support Team (IST) and the appropriate human rights committee.
- The efficacy of the plan must be reviewed not less than quarterly and adjusted as necessary.
- **The behavior specialist will provide a written report to pertinent parties at least quarterly.** *Pertinent parties* includes the individual, guardian, BDDS service coordinator, waiver case manager, all service providers, and other involved entities.

## Documentation Standards

- Services outlined in the ISP.
- Documentation in compliance with *460 IAC 6*.

Table 13.2 – Provider Licensure and Certification Table for Behavioral Support Services and Crisis Assistance

Waiver	Provider	License	Certification	Other Standard
DD, AU, SSW	Individual – types: DDRS approved BSS/Crisis Assistance individuals			DDRS-approved, <i>460 IAC 6-10-5 Criminal Histories</i> , <i>460 IAC 6-12 Insurance</i> , <i>460 IAC 6-11 Financial Status of Provider</i> , <i>460 IAC 6-5-4 Behavioral Support Services Provider Qualifications</i> and <i>460 IAC 6-18 Behavioral Support Services Standards</i> , <i>BDDS approval requirements</i>
DD, AU, SSW	Agency – types: DDRS approved BSS/Crisis Assistance agencies			Same as above

## Section 14: Case Management ICF/MR LOC Waivers

Table 14.1 – Description of Billing and Reimbursement for Case Management ICF/MR LOC Waivers

Procedure Code and Modifier	INsite Code	Procedure Code Description	Reimbursement/Unit Measurement Methodology	Waivers
T2022 U7	CMGT	Case Management	Based on an approved NOA Monthly rate	AU, DD, SSW
T2024 U7 U1	PCPA	Case Management Annual Plan facilitation	Based on an approved NOA Annual billing allowed on a rolling calendar year	AU, DD, SSW

### Definition of Service

**Please note that for individuals receiving services under the Autism, Developmental Disabilities or Support Services Waivers, Case Management is a Medicaid Administrative service and *not* a Medicaid Waiver service.**

Case Management Services means services that enable an individual to receive a full range of appropriate services in a planned, coordinated, efficient, and effective manner.

### Allowable Activities

- Monitoring of services as outlined in *460 IAC 6-19-6*
- Face-to-face contacts between the case manager and individual as required by *460 IAC 6-19(g)* and *(h)*
- Developing, updating, and reviewing Individualized Support Plan (ISP) using Person Centered Planning Process
- Completing and processing annual Level of Care
- Developing annual Cost Comparison Budgets using State approved process
- Disseminating information and forms to the individual and the Individualized Support Team (IST)
- Incident report completion, submission and follow-up
- Monitoring of service delivery and utilization via telephone calls, home visits and team meetings
- Monitoring individual satisfaction and service outcomes
- File maintenance
- Acting as an agent for the individual to assure the interests and preferences of the individual are represented across all environments; and strengthening informal and natural supports for each individual
- The negotiation of the best solutions for resource identification and other individual or system needs

### **Activities Not Allowed**

- Services delivered to an individual who does not meet eligibility requirements established by BDDS
- Counseling services related to legal issues. Such issues shall be directed to Indiana Protection and Advocacy Services, the designated Protection and Advocacy agency under the Developmental Disabilities Act and *Bill of Rights Act, P.L. 100-146*
- A person related through blood or marriage to any degree to an individual may not conduct case management for that individual

### **Service Standards**

- Case Management Services must be reflected in the Individual Support Plan (ISP).
- Services must address needs identified in the person centered planning process and be outlined in the ISP

### **Documentation Standards**

Documentation for Billing:

- Approved provider
- Must provide documentation identifying them as the case manager of record for the individual (the pick list is appropriate documentation)
- Case Managers are expected at a minimum to maintain a weekly summary for each individual. The weekly summary is a narrative that includes, but is not limited to:
  - Contacts with or on behalf of the individual or guardian
  - Any significant medical or behavioral issues
  - Any event that would result in an incident report and anything that needs a record for informational or follow-up purposes
  - If there is no interaction with, or on behalf of, a waiver individual in a given week, note of that is necessary
  - If activity-based chronological notes are preferred by the case manager, this may be done in place of the weekly summary (please note that at a minimum, a weekly note continues to be required even if using activity-based chronological notes instead of notes in a summary form)
- Documentation in compliance with *460 IAC 6-19*
- Documentation must be entered into the electronic data system within seven (7) days of the provision of services



## **Section 15: Case Management Nursing Facility LOC Waivers**

Table 15.1 – Description of Billing and Reimbursement for Case Management Nursing Facility LOC Waivers

<b>Procedure Code and Modifier</b>	<b>INsite Code</b>	<b>Procedure Code Description</b>	<b>Reimbursement/Unit Measurement Methodology</b>	<b>Waivers</b>
T1016 U7	CMGT	Case Management Services	Based on an approved NOA One unit = 15 minutes One hour = 4 units	AD, TBI

### **Definition of Service**

Case Management is a comprehensive service comprised of a variety of specific tasks and activities designed to coordinate and integrate all other services required in the individual's care plan. Case Management is required in conjunction with the provision of any home and community-based service.

### **Allowable Activities**

- Assessments of eligible clients to determine eligibility for services, functional impairment level, and corresponding in-home and community services needed by the client
- Development of care plans to meet the client needs
- Implementation of the care plans, linking client with needed services, regardless of the funding source
- Assessment and care planning for discharge from institutionalization
- Annual reassessments of clients needs
- Periodic updates of care plans
- Monitoring of the quality of home care community services provided to the client
- Determination of and monitoring the cost effectiveness of the provisions of in-home and community services
- Information and assistance services
- Enhancement or termination of services based on need

### **Activities Not Allowed**

- Case Management may not be conducted by any organization, entity, or individual that also delivers other in-home and community-based services, or by any organization, entity, or individual related by common ownership or control to any other organization, entity, or individual who also delivers other in-home and community-based services, unless the organization is an Area Agency on Aging that has been granted permission by the Family and Social Services Administration Division of Aging to provide direct services to clients.

*Note: Common ownership exists when an individual, individuals, or any legal entity possess ownership or equity of at least five percent in the provider as well as the institution or organization serving the provider. Control exists where an individual or organization has the power or the ability, directly or indirectly, to influence or direct the actions or policies of an organization or institution, whether or not actually exercised.*

*Related* means associated or affiliated with, or having the ability to control, or be controlled by.

- Independent case managers and independent case management companies may not provide initial applications for Medicaid Waivers and CHOICE funded services.
- Reimbursement of case management under Medicaid Waivers may not be made unless and until the client becomes eligible for Medicaid Waiver services. Case management provided to clients who are not eligible for Medicaid Waiver services will not be reimbursed as a Medicaid Waiver service.

### **Service Standards**

- Case Management Services must be reflected in the Cost Comparison Budget (CCB) of the individual.
- Services must address needs identified in the CCB.

### **Documentation Standards**

Documentation for Billing:

- Approved provider
- Must provide documentation identifying them as the case manager of record for the individual (the pick list is appropriate documentation)

Clinical/Progress Documentation:

- Services must be outlined in the POC/CCB.
- Evidence that individual requires the level of service provided.
- Documentation to support services rendered.

Table 15.2 – Provider Licensure and Certification Table for Case Management Nursing Facility Waivers

Waiver	Provider	License	Certification	Other Standard
AD, TBI	Qualified Individual and Agency Practitioners			DA-approved 460 IAC 1.2-6-2 General requirements, 460 IAC 1.2-6-3 General requirements for direct care staff, 460IAC 1.2-13 Professional qualifications and requirements, 460 IAC 1.2-14 Personnel Records, DA approval requirements 460 IAC 1.2-17-2 Case Management Training and Orientation DDRS certification or its designee Individual certification is through the local Area Agency on Aging (AAA)

## Section 16: Community Transition Services

Table 16.1 – Description of Billing and Reimbursement for Community Transition Services

Procedure Code and Modifier	INsite Code	Procedure Code Description	Reimbursement/Unit Measurement Methodology	Waivers
T2038 U7	CT	Community transition per service.	Based on an approved NOA One time set-up expenses, up to \$1,000.00.	AD, AU, DD

### Service Definition

Community Transition Services include reasonable, **one-time** set-up expenses for individuals who make the transition from an institution to their own home in the community and will not be reimbursable on any subsequent move.

*Note: Own Home is defined as any dwelling, including a house, an apartment, a condominium, a trailer, or other lodging that is owned, leased, or rented by the individual and/ or the individual's guardian or family, or a home that is owned and/ or operated by the agency providing supports.*

Items purchased through Community Transition Services are the property of the individual receiving the service, and the individual takes the property with him or her in the event of a move to another residence, even if the residence from which he or she is moving is owned by a provider agency. Nursing Facilities are not reimbursed for Community Transition Services because those services are part of the per diem. For those receiving this service under the A&D waiver, reimbursement for approved Community Transition Services expenditures are reimbursed through the local Area Agency on Aging (AAA)

### Allowable Activities

- Security deposits that are required to obtain a lease on an apartment or home.
- Essential furnishings and moving expenses required to occupy and use a community domicile including a bed, table or chairs, window coverings, eating utensils, food preparation items, bed or bath linens
- Set-up fees or deposits for utility or service access including telephone, electricity, heating, and water
- Health and safety assurances including pest eradication, allergen control, or one time cleaning prior to occupancy
- When the individual is receiving residential habilitation and support services under the DD or Autism Waiver, the Community Transition Supports service is included in the Cost Comparison Budget

### Activities Not Allowed

- Apartment or housing rental expenses
- Food

- Appliances
- Diversional or recreational items such as hobby supplies
- Television
- Cable TV access
- VCRs

### **Service Standards**

- Community Transition services must be reflected in the Cost Comparison Budget (CCB) of the individual.
- Services must address needs identified in the CCB.

### **Documentation Standards**

- Documentation requirements include maintaining receipts for all expenditures, showing the amount and what item or deposit was covered.

Table 16.2 – Provider Licensure and Certification Table for Community Transition Services

<b>Waiver</b>	<b>Provider</b>	<b>License</b>	<b>Certification</b>	<b>Other Standard</b>
AD	Agencies Individuals Utility Companies Retail Providers Property Owners/ Management Companies			DA-approved 460 IAC 1.2-6-2 General requirements, 460 IAC 1.2-6-3 General requirements for direct care staff, 460IAC 1.2-13 Professional qualifications and requirements, 460 IAC 1.2-14 Personnel Records, DA approval requirements
AU, DD	Agency – types: DDRS approved Residential Habilitation and Support Agencies			DDRS-approved agencies, 460 IAC 6-10-5 Criminal Histories, 460 IAC 6-12 Insurance, 460 IAC 6-11 Financial Status of Provider, 460 IAC 6-5-34 Staff Qualifications, 460 IAC 6-14-4 Staff Training, BDDS approval requirements
AU, DD	Individual – types: DDRS approved Residential Habilitation and Support provider			DDRS-approved agencies, 460 IAC 6-10-5, 460 IAC 6-12, 460 IAC 6-11, 460 IAC 6-5-34 Staff Qualifications, 460 IAC 6-14-4 Staff Training, BDDS approval requirements

## **Section 17: Day Habilitation/Structured Day Program**

Table 17.1 – Description of Billing and Reimbursement for Day Habilitation

<b>Procedure Code and Modifier</b>	<b>INsite Code</b>	<b>Procedure Code Description</b>	<b>Reimbursement/Unit Measurement Methodology</b>	<b>Waivers</b>
T2021 U7	DAY HABIL	Day Habilitation, day services per diem	Based on an approved NOA Daily rate	TBI
T2021 U7 HQ	DAY HABIL	Day Habilitation, Group Setting, per 15 minute units	Based on an approved NOA Unit = 15 minutes	TBI

### **Service Definition**

Assistance with acquisition, retention, or improvement in self-help, socialization and adaptive skills which takes place in a non residential setting, separate from the home or facility in which the individual resides. Services shall normally be furnished four (four) or more hours per day on a regularly scheduled basis, for one (1) or more days per week unless provided as an adjunct to other day activities included in an individual's plan of care.

### **Service Standards**

- Day Habilitation services shall focus on enabling the individual to attain or maintain his or her functional level
- Day Habilitation service shall be coordinated with any physical, occupational, or speech therapies listed in the plan of care
- Day Habilitation services may serve to reinforce skills or lessons taught in school, therapy, or other settings
- Transportation will be provided between the individual's place of residence and the site of the habilitative services (residential habilitation, day habilitation, supported employment), or between habilitation sites (in cases where the individual receives habilitation services in more than one place) as a component part of habilitation services. The cost of this transportation is included in the rate paid to providers of the appropriate type of habilitation services

### **Documentation Standards**

- Services outlined in Plan of Care/ Cost Comparison Budget (POC/CCB)
- A data record of staff to individual service documenting the names of both the staff and individual, the complete date and the start and stop time of the service (including a.m. or p.m.)
- Each staff that provides uninterrupted, continuous service in direct supervision or care of the individual must make one entry. If a staff member provided interrupted service (for example, one hour in the morning and one hour in the evening) an entry for each unique encounter must be made. All entries should describe an issue or circumstance concerning the individual.
- If the person providing the service is required to be professionally licensed, the title of the individual must also be included.

Table 17.2 – Provider Licensure and Certification Table for Day Habilitation

Waiver	Provider	License	Certification	Other Standard
TBI	Community Developmental Disabilities Agencies	IC 12-7-2-39	CARF	DA-approved 460 IAC 1.2-6-2 General requirements, 460 IAC 1.2-6-3 General requirements for direct care staff, 460 IAC 1.2-13 Professional qualifications and requirements, 460 IAC 1.2-14 Personnel Records, 460 IAC 1.2-12-1 Transportation of an individual, DA approval requirements Habilitation and rehabilitation services must be performed by persons who are supervised by a Qualified Mental Retardation Professional (QMRP) or a physical, occupational, or speech therapist licensed by the state of Indiana and has successfully completed training or has experience in conducting habilitation or rehabilitation programs.
TBI	Community Mental Health Centers	IC 12-7-2-38		Same as above
TBI	Rehab Facilities		CARF	Same as above

## Section 18: Day Services

Table 18.1 – Description of Billing and Reimbursement for Day Services

Procedure Code and Modifier	INsite Code	Procedure Code Description	Reimbursement/Unit Measurement Methodology	Waivers
T2020 U7 U1	DAYS	Day Services, day services per diem	Based on an approved NOA Daily rate	DD, SSW, AU

### Service Definition

Day Services means services outside of an individual's home that support, in general, learning and assistance in any of the following areas: self-care, receptive and expressive language, learning, mobility, self-direction and capacity for independent living, including development of employment skills. These activities are directly related to the Individualized Support Plan (ISP). Each individual receiving Day Services works toward acquiring the skills to become an active member of the community. The continuum of services within Day Services provides opportunities in facility based and the community based services to become more independent and more integrated within community activities. Day Services can be delivered to an individual one-on-one or in a group setting and in the community, work setting, or facility.

### Allowable Activities

- Direct supervision, monitoring, training, education, demonstration or support to assist with
- An individual's personal needs (feeding, toileting, and so forth)
- Transportation (excluding transportation that is covered under the Medicaid State Plan)
- Acquisition, improvement and retention of daily living skills
- Training and learning in the areas of employment skills, educational opportunities, hobbies and leisure activities
- Development of self-advocacy skills, acquiring skills that enable an individual to exercise control and responsibility over services and supports received or needed
- Activities that are directly related to the outcomes outlined in the Individualized Support Plan (ISP)
- Prevocational related activities that are compensated and paid to the individual at less than 50 percent of the minimum wage

### Activities Not Allowed

- Services furnished to a minor by the parent(s), step-parent(s), or legal guardian
- Services furnished to an individual by the person's spouse
- Any service that is otherwise available under the *Rehabilitation Act of 1973* or *Public Law 94-124*
- Services that are available under the Medicaid State Plan

### Service Standards

- Day Services must be reflected in the ISP.

- Services must address needs identified in the person centered planning process and be outlined in the ISP.

## Documentation Standards

Day Services documentation must include:

- Approved provider credentials
- Documentation for each day of service rendered. The specific data elements required for each day of service include the following:
  - Type and unit of service
  - Name of individual served
  - RID Number of the individual
  - Date of service (including the year)
  - Notation of the primary location at which the service was rendered
  - A description of an issue or circumstance concerning the individual made by direct care staff. The entry should include complete time and date of the entry (include a.m. or p.m.) and a signature that includes at least the last name and first initial of the direct care staff person making the entry. Electronic signatures are acceptable if the provider has a log on file that shows the staff member's electronic signature, their actual signature and their printed name. A minimum of one entry per shift is required.
- Documentation in compliance with 460 IAC 6

Clinical or progress documentation is also required and must include:

- The provider must complete a monthly summary of the individual's progress towards outcomes, using the approved form. This is a narrative summary, about one page in length, that describes the individual's day service activities, and must address outcomes in the individual's ISP, as well as a high level summary of issues affecting the health, safety and welfare of the individual requiring intervention by a healthcare professional, case manager, behavior support services provider or BDDS staff member.
- This documentation will be reviewed as part of the BQIS quality reviews. Failure to maintain these monthly summaries as described above will be considered a violation of the Medicaid provider agreement and reimbursement for services will not be available.

Table 18.2 – Provider Licensure and Certification Table for Day Services

Waiver	Provider	License	Certification	Other Standard
DD, AU, SSW	Agency – types: DDRS approved agencies			DDRS-approved, 460 IAC 6-10-5 <i>Criminal Histories</i> , 460 IAC 6-12 <i>Insurance</i> , 460 IAC 6-11 <i>Financial Status of Provider</i> , 460 IAC 6-5-30 <i>Transportation</i> , 460 IAC 6-5-14 <i>Health Care Coordination Services provider qualifications</i> , <i>Qualifications outlined in 460 IAC 6 Provider Rules</i> , 6-14-5 <i>Direct Care Staff qualifications</i> , and 460 IAC 6- 5-29 <i>Supported Employment Services provider qualifications</i> , 460 IAC 6-5-20 <i>Pre-vocational Services provider qualifications</i> , 460 IAC 6-14-4 <i>Staff Training</i> , BDDS approval requirements



Table 18.2 – Provider Licensure and Certification Table for Day Services

Waiver	Provider	License	Certification	Other Standard
AU, DD, SSW	Individuals – types: DDRS approved individuals			DDRS-approved, 460 IAC 6-10-5 <i>Criminal Histories</i> , 460 IAC 6-12 <i>Insurance</i> , 460 IAC 6-11 <i>Financial Status of Provider</i> , 460 IAC 6-5-30 <i>Transportation</i> , 460 IAC 6-5-14 <i>Health Care Coordination Services provider qualifications</i> , <i>Qualifications outlined in 460 IAC 6 Provider Rules</i> , 6-14-5 <i>Direct Care Staff qualifications</i> , and 460 IAC 6- 5-29 <i>Supported Employment Services provider qualifications</i> , 460 IAC 6-14-4 <i>Staff Training</i> , BDDS approval requirements

## Section 19: Environmental Modifications

Table 19.1 – Description of Billing and Reimbursement for Environmental Modifications

Procedure Code and Modifier	INsite Code	Procedure Code Description	Reimbursement/Unit Measurement Methodology	Waivers
S5165 U7 NU	EMOI	Home Modification, per service, new modification	Based on an approved NOA and RFA One Unit equals the approved amount on the CCB	AD, AU, DD, TBI
S5165 U7 RP	EMOM	Home Modification, per service, replacement and repair	Based on an approved NOA and RFA One Unit equals the approved amount on the CCB	AD, AU, DD, TBI
T1028 U7	INSP	Assessment/Inspection/ Training	Unit = 15 minutes	AU, DD

### Service Definition

Those physical adaptations to the home, required by the individual's plan of care, which are necessary to ensure the health, welfare and safety of the individual, or which enable the individual to function with greater independence in the home, and without which the individual would require institutionalization.

Waiver Services must approve all environmental modifications prior to service being rendered.

### Allowable Activities

- Installation of ramps and grab bars
- Widening doorways
- Modifying bathroom facilities
- Installation of specialized electric and plumbing systems necessary to accommodate the medical equipment and supplies which are necessary for the welfare of the individual
- Maintenance and repair of the items and modifications installed during the initial request
- Anti-scald devices

### Activities Not Allowed

- Adaptations to the home which are of general utility
- Adaptations which are not of direct medical or remedial benefit to the individual (such as carpeting, roof repair, central air conditioning)
- Adaptations which add to the total square footage of the home
- Adaptations that are not included in the comprehensive plan of care
- Adaptations that have not been approved on a Request for Approval to Authorize Services

### Service Standards

- Equipment and supplies must be for the direct medical or remedial benefit of the individual

- All items shall meet applicable standards of manufacture, design and installation
- Reimbursement for Environmental Modification Supports has a lifetime cap of \$15,000. Service and repair up to \$500 per year, outside this cap, is permitted for maintenance and repair of prior modifications. (If the lifetime cap is fully utilized, and a need is identified, the case manager will work with other available funding streams and community agencies to fulfill the need.)

To ensure that environmental modifications meet the needs of the individual and abide by established, federal, state, local and FSSA standards, as well as ADA requirements, approved environmental modifications will reimburse for necessary:

- Assessment of the individual's specific needs, conducted by an approved, qualified individual who is independent of the entity providing the environmental modifications
- Independent inspections during the modification process and at completion of the modifications, prior to authorization for reimbursement, based on the complexities of the requested modifications.

**DD, AU:**

- Equipment and supplies shall be reflected in the Individualized Support Plan
- Equipment and supplies must address needs identified in the person centered planning process

**Documentation Standards**

- Identified direct medical benefit for the individual
- Documented "Prior Authorization Denial" from Medicaid, if applicable
- Receipts for purchases

**DD, AU:**

- Identified need in Individualized Support Plan
- Documentation in compliance with 460 IAC 6

Table 19.2 – Provider Licensure and Certification Table for Environmental Modifications

Waiver	Provider	License	Certification	Other Standard
AD, TBI	Qualified contractors	Any applicable licensure such as architects and contractors must be in place, IC 25-4, IC 25-28.5 Home inspectors IC 25-20.2 Evaluators such as OT IC 25-23.5 PT IC 25-27 or Speech and Language Therapists IC 25-35.6		DA-approved 460 IAC 1.2-6-2 General requirements, 460 IAC 1.2-6-3 General requirements for direct care staff, 460 IAC 1.2-13 Professional qualifications and requirements, 460 IAC 1.2-14 Personnel Records, DA approval requirements 460 IAC 1.2-18-1 Warranty Required, 460 IAC 1.2 General Requirements
DD, AU	Individual – types: Qualified contractors, architects, licensed contractors, builders, individuals, home inspectors, plumbers, licensed PT, OT, ST	Home inspectors: IC 25-20.2 Plumbers: IC 25-28.5	Architects: IC 25-4	DDRS-approved, 460 IAC 6-10-5 Criminal Histories, 460 IAC 6-12 Insurance, 460 IAC 6-11 Financial Status of Provider, 460 IAC 6-5-11 Environmental Modification Qualifications

Table 19.2 – Provider Licensure and Certification Table for Environmental Modifications

Waiver	Provider	License	Certification	Other Standard
DD, AU	Agency – types: Qualified contractors, architects, licensed contractors, builders, individuals, home inspectors, plumbers, licensed PT, OT, ST			DDRS-approved, 460 IAC 6-10-5 Criminal Histories, 460 IAC 6-12, 460 IAC 6-11, 460 IAC 6-5-11

## **Section 20: Family and Caregiver Training Services**

Table 20.1 – Description of Billing and Reimbursement for Family and Caregiver Training Services

<b>Procedure Code and Modifier</b>	<b>INsite Code</b>	<b>Procedure Code Description</b>	<b>Reimbursement/Unit Measurement Methodology</b>	<b>Waivers</b>
S5111 U7	FCAR	Family Home Care Training, per session	Based on an approved NOA One unit equals one session approved on the CCB	AU, DD, SSW
S5116 U7	FCNF	Non-family Home Care Training, per session	Based on an approved NOA One unit equals one session approved on the CCB	AU, DD, SSW

### **Service Definition**

Family and Caregiver Training Services provides training and education (1) to instruct a parent, other family member, or primary caregiver about the treatment regimens and use of equipment specified in the Individualized Support Plan; and (2) to improve the ability of the parent, family member or primary caregiver to provide the care to or for the individual.

### **Allowable Activities**

- Treatment regimens and use of equipment
- Stress management
- Parenting
- Family dynamics
- Community integration
- Behavioral intervention strategies
- Mental health
- Caring for medically fragile individuals

### **Activities Not Allowed**

- Training/instruction not pertinent to the caregiver's ability to give care to the individual
- Training provided to caregivers who receive reimbursement for training costs within their Medicaid or state line item reimbursement rates
- Meals, accommodations, etc., while attending the training

### **Service Standards**

- Family and Caregiver Training Services must be included in the Individualized Support Plan

- The Individualized Support Plan shall be based on the person centered planning process with that individual.
- Funds are limited to no more than \$2,000/year

### **Documentation Standards**

- Services outlined in the Individualized Support Plan
- Receipt of payment for activity
- Proof of participation in activity if payment is made directly to individual/family.
- Documentation in compliance with 460 IAC 6

Table 20.2 – Provider Licensure and Certification Table for Family and Caregiver Training Services

<b>Waiver</b>	<b>Provider</b>	<b>License</b>	<b>Certification</b>	<b>Other Standard</b>
DD, AU, SSW	Individuals – types: Individuals approved by DDRS to provide Residential Habilitation and Supports Services			DDRS-approved, 460 IAC 6-10-5 Criminal Histories, 460 IAC 6-12 Insurance, 460 IAC 6-11 Financial Status of Provider, 460 IAC 6-5-13 Family and Caregiver Training Qualifications, 460 IAC 6-14-4 Staff Training, BDDS approval requirements
DD,AU, SSW	Agency – types: Agencies approved by DDRS to provide Residential Habilitation and Supports Services			DDRS-approved, 460 IAC 6-10-5 Criminal Histories, 460 IAC 6-12 Insurance, 460 IAC 6-11 Financial Status of Provider, 460 IAC 6-5-13 Family and Caregiver Training Qualifications, 460 IAC 6-14-4 Staff Training, BDDS approval requirements

## Section 21: Health Care Coordination Services

Table 21.1 – Description of Billing and Reimbursement for Health Care Coordination Services

Procedure Code and Modifier	INsite Code	Procedure Code Description	Reimbursement	Waivers
T2022 U7 U1	HCC1	Health Care Coordination, Level 1	Based on an approved NOA Monthly rate	TBI
T2022 U7 U2	HCC2	Health Care Coordination, Level 2	Based on an approved NOA Monthly rate	TBI

### Service Definition

Health Care Coordination includes medical coordination provided by a Registered Nurse (RN) or a Licensed Practical Nurse (LPN) to manage the health care of the individual including physician consults, medication ordering, and development and nursing oversight of a healthcare support plan. Skilled nursing services are provided within the scope of the Indiana State Nurse Practice Act. The purpose of Health Care Coordination is stabilization; prevention of decompensation; management of chronic conditions; and/or improved health status.

Because of the different benefits provided under Skilled Nursing and Health Care Coordination, Medicaid Prior Authorization for skilled nursing services is **not** necessary prior to the provision of Health Care Coordination. Health Care Coordination consists of the following levels:

- One Unit – Health care needs require at least weekly consultation or review with an RN or LPN with face-to-face visits once a month
- Two Units – Health care needs require at least twice weekly consultation or review with an RN or LPN with face to face visits at least once a week

The appropriate level should be determined by a healthcare professional (RN, doctor).

### Allowable Activities

- Physician consults
- Medication ordering
- Development and oversight of a healthcare support plan

### Activities Not Allowed

- Skilled nursing services that are available under the Medicaid State plan
- Case management services provided under a 1915(b), 1915(c), or 1915(g) case management waiver
- Residential, vocational, and/or educational services otherwise provided by the TBI waiver

### Service Standards

- Weekly consultations or reviews
- Face to face visits with the individual

- Other activities, as appropriate
- Services must address needs identified in the plan of care/CCB
- The provider of home health care coordination will provide a written report to pertinent parties at least quarterly. *Pertinent parties* includes the individual, guardian, waiver case manager, all service providers, and other entities.

### **Documentation Standards**

- Current RN or LPN license for each nurse
- Evidence of a consultation including complete date and signature. Consultation can be with other staff, client, other professionals, as well as health care professionals.
- Evidence of a face-to-face visit with the member, including complete date and signature.

Table 21.2 – Provider Licensure and Certification Table for Health Care Coordination Services

<b>Waiver</b>	<b>Provider</b>	<b>License</b>	<b>Certification</b>	<b>Other Standard</b>
TBI	Licensed Home Health Agencies	Licensed by ISDH <i>IC 16-27-1</i> Home Health Agency <i>410 IAC 17-2</i> Licensed by ISDH RN and LPN <i>IC 25-23</i>		DA-approved <i>460 IAC 1.2-6-2 General requirements, 460 IAC 1.2-6-3 General requirements for direct care staff, 460 IAC 1.2-13 Professional qualifications and requirements, 460 IAC 1.2-14 Personnel Records, DA approval requirements</i>



## Section 22: Home-Delivered Meals

Table 22.1 – Description of Billing and Reimbursement for Home-Delivered Meals

Procedure Code and Modifier	INsite Code	Procedure Code Description	Reimbursement/Unit Measurement Methodology	Waivers
S5170 U7	HDM	Home delivered meals, including preparation, per meal	Based on an approved NOA One unit is one meal	AD

### Service Definition

A Home Delivered Meal is a nutritionally balanced meal. This service is essential in preventing institutionalization because the absence of nutrition in individuals with frail and disabling conditions presents a severe risk to health. No more than two meals per day will be reimbursed under the waiver.

### Allowable Activities

- Provision of meals
- Diet/ nutrition counseling provided by a registered dietician
- Nutritional education
- Diet modification according to a physician's order as required meeting the recipient's medical and nutritional needs.

### Activities Not Allowed

- No more than two meals per day will be reimbursed under the waiver.

### Service Standards

- Home Delivered Meals will be provided to persons who are unable to prepare their own meals and for whom there are no other person's available to do so or where the provision of a home delivered meal is the most cost-effective method of delivering a nutritionally adequate meal.
- All meals must meet safety, sanitary, and nutrient standards.
- All home delivered meals provided must contain at least 1/3 of the current recommended dietary allowance (RDA) as established by the Food and Nutrition Board of the National Academy of Sciences, National Research council. Menu plans will be reviewed and approved by a registered, licensed dietician.

### Documentation Standards

- Identified need in the POC/CCB.
- Date of service and units of service documented

Table 22.2 – Provider Licensure and Certification Table for Home-Delivered Meals

Waiver	Provider	License	Certification	Other Standard
AD	Qualified Agencies			<p>Must comply with all State and local health laws and ordinances concerning preparation, handling, and serving of food.</p> <p>If the agency is also a Title III-C2 nutrition provider, requirements of the Older Americans Act must be met.</p> <p>DA-approved 460 IAC 1.2-6-2 General requirements, 460 IAC 1.2-6-3 General requirements for direct care staff, 460 IAC 1.2-13 Professional qualifications and requirements, 460 IAC 1.2-14 Personnel Records, DA approval requirements</p>

## Section 23: Homemaker Services

Table 23.1 – Description of Billing and Reimbursement for Homemaker Services

Procedure Code and Modifier	INsite Code	Procedure Code Description	Reimbursement/Unit Measurement Methodology	Waivers
S5130 U7	HMK	Homemaker Services, NOS, per 15 minute units (for non agency use)	Based on an approved NOA One unit = 15 minutes One hour = 4 units	AD, TBI
S5130 U7 UA	HMK	Homemaker Services, NOS, per 15 minute units (for agency use)	Based on an approved NOA One unit = 15 minutes One hour = 4 units	AD, TBI

### Definition of Service

Homemaker services offer direct and practical assistance consisting of household tasks and related activities. Homemaker services assist the individual to remain in a clean, safe, healthy home environment. Homemaker services are provided when the individual is unable to meet these needs or when an informal caregiver is unable to meet these needs for the individual.

### Allowable Activities

- Provides housekeeping tasks which include:
  - dusting and straightening furniture
  - cleaning floors and rugs by wet or dry mop and vacuum sweeping
  - cleaning the kitchen, including washing dishes, pots, and pans; cleaning the outside of appliances and counters and cupboards; cleaning ovens and defrosting and cleaning refrigerators
  - maintaining a clean bathroom, including cleaning the tub, shower, sink, toilet bowl, and medicine cabinet; emptying and cleaning commode chair or urinal
  - laundering clothes in the home or Laundromat, including washing, drying, folding, putting away, ironing, and basic mending and repair
  - changing linen and making beds
  - washing insides of windows
  - removing trash from the home
  - choosing appropriate procedures, equipment, and supplies; improvising when there are limited supplies, keeping equipment clean and in its proper place
  - cleaning up of the yard which is defined as: lawn mowing, raking, and snow removal.
- Provides assistance with meals or nutrition which includes:
  - shopping, including planning and putting food away;
  - making meals, including special diets under the supervision of a registered dietitian or health professional.
- Runs the following essential errands:
  - grocery shopping
  - household supply shopping
  - prescription pick up
- Provides assistance with correspondence and bill paying

### Activities Not Allowed

- Assistance with *hands on* services such as eating, bathing, dressing, personal hygiene, and activities of daily living
- Homemaker services provided to household members other than the individual

### Service Standards

- Homemaker services must follow a written Plan of Care addressing specific needs determined by the client's assessment.

### Documentation Standards

- Identified need in the POC/CCB
- Date of service and unit(s) of service
- Documentation of services delivered.

Table 23.2 – Provider Licensure and Certification Table for Homemaker Services

Waiver	Provider	License	Certification	Other Standard
AD, TBI	Community Developmental Disabilities Agencies	IC-12-7-2-39	CARF	DA-approved 460 IAC 1.2-6-2 General requirements, 460 IAC 1.2-6-3 General requirements for direct care staff, 460 IAC 1.2-13 Professional qualifications and requirements, 460 IAC 1.2-14 Personnel Records, DA approval requirements
	Licensed Home Health Agencies	IC 16-27-1 Home Health Agency 410 IAC 17-2 Licensed by Indiana State Department of Health		Agencies providing homemaker services must comply with standards developed by the Indiana Association of Home Services Agencies, Inc. (IAHSA), or be enrolled in the Indiana Medicaid Program as a home health agency after meeting the standards used by the Indiana Medicaid program
	Individuals Family members			Homemaker services may not be reimbursed when provided by a spouse or a parent of a minor child or by any member of the individual's household.

## Section 24: Music Therapy

Table 24.1 – Description of Billing and Reimbursement for Music Therapy

Procedure Code and Modifier	INsite Code	Procedure Code Description	Reimbursement/Unit Measurement Methodology	Waivers
H2032 U7 U1	MUTH	Activity Therapy, Waiver, Music, 15 minute units	Based on an approved NOA One unit = 15 minutes One hour = 4 units	AU, DD, SSW

### Service Definition

Music Therapy Services means services provided for the systematic application of music in the treatment of the physiological and psychosocial aspects of an individual's disability and focusing on the acquisition of nonmusical skills and behaviors.

### Allowable Activities

- Therapy to improve
  - Self-image and body awareness
  - Fine and gross motor skills
  - Auditory perception
- Therapy to increase
  - Communication skills
  - Ability to use energy purposefully
  - Interaction with peers and others
  - Attending behavior
  - Independence and self-direction
- Therapy to reduce maladaptive (stereotypic, compulsive, self-abusive, assaultive, disruptive, perseverative, impulsive) behaviors.
- Therapy to enhance emotional expression and adjustment.
- Therapy to stimulate creativity and imagination. The music therapist may provide services directly or may demonstrate techniques to other service personnel or family members

### Activities Not Allowed

- When services are reimbursable through the Medicaid State Plan.
- Specialized equipment needed for the provision of Music Therapy Services should be purchased under "Specialized Medical Equipment and Supplies Supports"

### Service Standards

- Music Therapy Services should be reflected in the Individualized Support Plan of the individual
- Services must address needs identified in the person centered planning process and be outlined in the Individualized Support Plan. Services must complement other services the individual receives and enhance increasing health and safety for the individual

## Documentation Standards

- Documentation of appropriate assessment by a qualified therapist
- Services outlined in Individualized Support Plan
- Documentation in compliance with *460 IAC 6*
- Appropriate credentials for service provider
- Attendance record, therapist logs and/or chart detailing service provided, date and times
- Documentation in compliance with *460 IAC 6*

Table 24.2 – Provider Licensure and Certification Table for Music Therapy

Waiver	Provider	License	Certification	Other Standard
DD, AU, SSW	Agency – types: Agency that employs Approved Music Therapist		By a Certification Board for Music Therapist, that is Accredited by a National Committee for Certifying Agencies	DDRS-approved <i>460 IAC 6-10-5 Criminal Histories</i> , <i>460 IAC 6-12 Insurance</i> , <i>460 IAC 6-11 Financial Status of Provider</i> , <i>460 IAC 6-5-15 Music Therapy Provider qualifications</i> , <i>BDDS approval requirements</i>
AU, DD, SSW	Individual – types: Approved Music Therapist		Certified Music Therapist – Same as above	<i>460 IAC 6-10-5 Criminal Histories</i> , <i>460 IAC 6-12</i> , <i>460 IAC 6-11</i> , <i>460 IAC 6-5-15</i> , <i>BDDS approval requirements</i>

## Section 25: Nutritional Supplements

Table 25.1 – Description of Billing and Reimbursement for Nutritional Supplements

Procedure Code and Modifier	INsite Code	Procedure Code Description	Reimbursement/Unit Measurement Methodology	Waivers
B4150 U7	NUTS	Nutritional Supplement	Based on an approved NOA	AD

### Service Definition

Nutritional (Dietary) supplements include liquid supplements, such as “Boost” or “Ensure” to maintain an individual’s health in order to remain in the community.

Supplements should be ordered by a physician based on specific life stage, gender, and/ or lifestyle.

Reimbursement for approved Nutritional Supplement expenditures are reimbursed through the local Area Agency on Aging (AAA)

### Allowable Activities

- Ensure nutritional supplement (Enteral Formulae, category 1)
- Boost nutritional supplement (Enteral Formulae, category 1)

### Documentation Standards

- Identified need in the POC/CCB

Table 25.2 – Provider Licensure and Certification Table for Nutritional Supplements

Waiver	Provider	License	Certification	Other Standard
AD	Agencies Retail Providers			DA-approved 460 IAC 1.2-6-2 General requirements, 460 IAC 1.2-6-3 General requirements for direct care staff, 460IAC 1.2-13 Professional qualifications and requirements, 460 IAC 1.2-14 Personnel Records, DA approval requirements

## Section 26: Occupational Therapy Services

Table 26.1 – Description of Billing and Reimbursement for Occupational Therapy Services

Procedure Code and Modifier	INsite Code	Procedure Code Description	Reimbursement/Unit Measurement Methodology	Waivers
G0152 U7 UA	OCTH	Occupational Therapist in home health setting, per 15 minute units	Based on an approved NOA One unit = 15 minutes One hour = 4 units	AU, DD, SSW, TBI

### Service Definition

Occupational Therapy Services means services provided under this article by a licensed occupational therapist.

### Allowable Activities

- Evaluation and training services in the areas of gross and fine motor function, self-care and sensory and perceptual motor function.
- Screening
- Assessments
- Planning and reporting
- Direct therapeutic intervention
- Design, fabrication, training and assistance with adaptive aids and devices
- Consultation or demonstration of techniques with other service providers and family members
- Participating on the interdisciplinary team, when appropriate, for the development of the plan

### Activities Not Allowed

- Activities not delivered one-on-one with the individual
- Activities delivered in a nursing facility
- Activities that are available through the Medicaid State Plan (such as, a Medicaid State Plan prior authorization denial is required before reimbursement is available through the Medicaid waiver for this service).

### Service Standards

- Individual Occupational Therapy Services must be reflected in the Individualized Support Plan.
- The need for such services must be documented by an appropriate assessment and authorized in the individual's service plan.

### Documentation Standards

- Documentation by appropriate assessment by a qualified therapist



- Services outlined in the Individualized Support Plan
- Appropriate credentials for service provider
- Attendance record, therapist logs and/or chart detailing service provided, date and times
- Documentation in compliance with 460 IAC 6

Table 26.2 – Provider Licensure and Certification Table for Occupational Therapy Services

Waiver	Provider	License	Certification	Other Standard
DD, AU, SSW	Agency – types: Home Health Agencies Therapy Agencies	IC 16-27-1		DDRS-approved, 460 IAC 6-10-5 Criminal Histories, 460 IAC 6-12 Insurance, 460 IAC 6-11 Financial Status of Provider, 460 IAC 6-5-17 Occupational Therapy Provider Qualifications, BDDS approval requirements
DD, AU, SSW	Individual – types: Certified Occupational Therapist and Qualified Paraprofessionals		Occupational Therapist: IC 25-23.5 Occupational Therapy Assistant: IC 25-23.5-5 Occupational Therapy Aide	DDRS-approved, 460 IAC 6-10-5 Criminal Histories, 460 IAC 6-12, 460 IAC 6-11, 460 IAC 6-5-17 Occupational Therapy Qualifications, BDDS Approval requirements Same as above and IC 25-23.5-1-5.5 and 844 IAC 10-6 requirements for occupational therapy aide
TBI	Same as above		Same as above	DA- approved 460 IAC 1.2-6-2 General requirements, 460 IAC 1.2-6-3 General requirements for direct care staff, 460 IAC 1.2-13 Professional qualifications and requirements, 460 IAC 1.2-14 Personnel Records, DA approval requirements

## **Section 27: Personal Emergency Response System Supports**

Table 27.1 – Description of Billing and Reimbursement for Personal Emergency Response System Supports

Procedure Code and Modifier	INsite Code	Procedure Code Description	Reimbursement/Unit Measurement Methodology	Waivers
S5160 U7	PRSI	Emergency Response System, Installation and Testing	Based on an approved NOA One unit	AD, AU, DD,SSW, TBI,
S5161 U7	PRSM	Emergency Response System, Maintenance Service fee	Based on an approved NOA Monthly rate	AD, AU, DD,SSW, TBI,

### **Service Definition**

PERS is an electronic device which enables certain individuals at high risk of institutionalization to secure help in an emergency. The individual may also wear a portable *help* button to allow for mobility. The system is connected to the person's phone and programmed to signal a response center once a "help" button is activated. The response center is staffed by trained professionals.

### **Allowable Activities**

- PERS is limited to those individuals who live alone, or who are alone for significant parts of the day, and have no regular caregiver for extended periods of time, and who would otherwise require extensive supervision.
- Device Installation service
- Ongoing monthly maintenance of device

### **Activities Not Allowed**

- Reimbursement is not available for Personal Emergency Response System Supports when the individual requires constant supervision to maintain health and safety.

### **Service Standards**

- Must be included in the individual's plan of care.

### **Documentation Standards**

- Identified need in the POC/CCB
- Documentation of expense for installation
- Documentation of monthly rental fee

Table 27.2 – Provider Licensure and Certification Table for Personal Emergency Response System Supports

Waiver	Provider	License	Certification	Other Standard
AU, DD, SSW	Agency – types: DDRS approved agencies			DDRS-approved, 460 IAC 6-10-5 Criminal Histories, 460 IAC 6-12 Insurance, 460 IAC 6-11 Financial Status of Provider, 460 IAC 6-5-18 PERS Qualifications, BDDS Approval requirements, 460 IAC 6-28-1 PERS Warranty of work
AD, TBI	Medical Supply Companies			DA-approved 460 IAC 1.2-6-2 General requirements, 460 IAC 1.2-6-3 General requirements for direct care staff, 460 IAC 1.2-13 Professional qualifications and requirements, 460 IAC 1.2-14 Personnel Records, DA approval requirements, 460 IAC 1.2-18-1 Warranty Required

## Section 28: Pest Control

Table 28.1 – Description of Billing and Reimbursement for Pest Control

Procedure Code and Modifier	INsite Code	Procedure Code Description	Reimbursement/Unit Measurement Methodology	Waivers
T2025 U7 U1	PEST	Waiver Services NOS (not otherwise specified) Pest control	Based on an approved NOA One unit = one application	AD

### Service Definition

Pest Control services are designed to prevent, suppress, or eradicate anything that competes with humans for food and water, injures humans, spreads disease to humans and/ or annoys humans and is causing or is expected to cause more harm than is reasonable to accept. Pests include insects such as roaches, mosquitoes, and fleas; insect-like organisms, such as mites and ticks; and vertebrates, such as rats and mice.

Services to control pests are services that prevent, suppress, or eradicate pest infestation.

Reimbursement for approved Pest Control expenditures are reimbursed through the local Area Agency on Aging (AAA)

### Allowable Activities

- Pest Control services are added to the Plan of Care when the Case Manager determines-either through direct observation or client report- that a pest is present that is causing or is expected to cause more harm than is reasonable to accept.
- Services to control pests are services that prevent, suppress, or eradicate pest infestation.

### Activities Not Allowed

- Pest Control services may not be used solely as a preventative measure, there must be documentation of a need for this service either through Care Manager direct observation or individual report that a pest is causing or is expected to cause more harm than is reasonable to accept

### Service Standards

- Pest control service must be reflected in the individual plan of care.

### Documentation Standards

- Identified need in the POC/CCB
- Receipts of specific service, date of service, and cost of service completed.

Table 28.2 – Provider Licensure and Certification Table for Pest Control

Waiver	Provider	License	Certification	Other Standard
AD	Qualified pest control companies and individuals	IC 15-3-3.6		<p>DA-approved 460 IAC 1.2-6-2 General requirements, 460 IAC 1.2-6-3 General requirements for direct care staff, 460 IAC 1.2-13 Professional qualifications and requirements, 460 IAC 1.2-14 Personnel Records, DA approval requirements</p> <p>Pesticide applicators must be certified or licensed through the Purdue University Extension Service and the Office of the Indiana State Chemist.</p>

## Section 29: Physical Therapy Services

Table 29.1 – Description of Billing and Reimbursement for Physical Therapy Services

Procedure Code and Modifier	INsite Code	Procedure Code Description	Reimbursement/Unit Measurement Methodology	Waivers
G0151 U7 UA	PTH	Physical Therapy in home health setting.	Based on an approved NOA One unit = 15 minutes One hour = 4 units	AU, DD, SSW, TBI

### Service Definition

Physical Therapy Services means services provided under this article by a licensed physical therapist  
Allowable Activities

### Allowed Activities

- Screening and assessment
- Treatment and training programs designed to preserve and improve abilities for independent functioning, such as gross and fine motor skills, range of motion, strength, muscle tone, activities of daily living
- Planning and reporting
- Direct therapeutic intervention
- Training and assistance with adaptive aids and devices
- Consultation or demonstration of techniques with other service providers and family members
- Participating on the interdisciplinary team, when appropriate, for the development of the service plan

### Activities Not Allowed

- Activities not delivered one-on-one with the individual
- Activities delivered in a nursing facility
- Activities available through the Medicaid State Plan (such as, a Medicaid State Plan prior authorization denial is required before reimbursement is available through BDDS for this service)

### Service Standards

- Individual Physical Therapy Services must be reflected in the Individualized Support Plan.
- The need for such services must be documented by an appropriate assessment and authorized in the individual's service plan.

### Documentation Standards

- Physical Therapy Services documentation must include:
- Documentation by appropriate assessment

- Services outlined in the Individualized Support Plan
- Appropriate credentials for service provider
- Attendance record, therapist logs, and chart detailing service provided, date, and times.
- Documentation in compliance with 460 IAC 6

Table 29.2 – Provider Licensure and Certification Table for Physical Therapy Services

Waiver	Provider	License	Certification	Other Standard
DD, AU, SSW	Individual – types: Licensed Physical Therapist and Qualified Paraprofessional	Physical Therapist: <i>IC 25-27-1</i>		DDRS-approved, 460 IAC 6-10-5 <i>Criminal Histories</i> , 460 IAC 6-12 <i>Insurance</i> , 460 IAC 6-11 <i>Financial Status of Provider</i> , 460 IAC 6-5-19 <i>PT Provider Qualifications</i> , <i>BDDS approval requirements</i>
DD, AU, SSW	Agency – types: Home Health Agencies, Therapy Agencies	<i>IC 16-27-1</i>		Same as above
TBI	Same as above	Same as above		DA-approved 460 IAC 1.2-6-2 <i>General requirements</i> , 460 IAC 1.2-6-3 <i>General requirements for direct care staff</i> , 460 IAC 1.2-13 <i>Professional qualifications and requirements</i> , 460 IAC 1.2-14 <i>Personnel Records</i> , <i>DA approval requirements</i>

## Section 30: Recreational Therapy Services

Table 30.1 – Description of Billing and Reimbursement for Recreational Therapy Services

Procedure Code and Modifier	INsite Code	Procedure Code Description	Reimbursement/Unit Measurement Methodology	Waivers
H2032 U7 U2	RETH	Activity therapy, waiver, recreational therapy.	Based on an approved NOA One unit = 15 minutes One hour = 4 units	AU, DD, SSW

### Service Definition

Recreational Therapy Services means services provided under this article and consisting of a medically approved recreational program to restore, remediate, or rehabilitate an individual in order to (1) improve the individual's functioning and independence and (2) reduce or eliminate the effects of an individual's disability.

### Allowed Activities

- Planning, organizing and directing, Adapted sports, Dramatics, Arts and crafts, Social activities, other recreation services designed to restore, remediate or rehabilitate.

### Activities Not Allowed

- Payment for the actual activities being planned, organized and directed, when the services are reimbursable through the Medicaid State Plan.

### Service Standards

- Recreational Therapy Services should be reflected in the Individualized Support Plan of the individual.
- Services must address needs identified in the person centered planning process and be outlined in the Individualized Support Plan.
- Services must complement other services the individual receives and enhance increasing independence for the individual

### Documentation Standards

- Documentation by appropriate assessment
- Services outlined in Individualized Support Plan
- Appropriate credentials for service provider
- Attendance record, therapist logs, and/or chart detailing service provided, date, and times
- Documentation in compliance with 460 IAC 6



Table 30.2 – Provider Licensure and Certification Table for Recreational Therapy Services

Waiver	Provider	License	Certification	Other Standard
DD, AU, SSW	Agency – types: Agency that employs Approved Recreational Therapist			DDRS-approved, 460 IAC 6-10-5 <i>Criminal Histories</i> , 460 IAC 6-12 <i>Insurance</i> , 460 IAC 6-11 <i>Financial Status of Provider</i> , 460 IAC 6-5-22 <i>Recreational Therapy Provider Qualifications</i> , BDDS approval <i>requirements</i>
AU, DD, SSW	Individual – types: Approved Recreational Therapist			460 IAC 6-10-5 <i>Criminal Histories</i> , 460 IAC 6-12, 460 IAC 6-11, 460 IAC 6-5-22, BDDS approval <i>requirements</i>

## **Section 31: Rent and Food for Unrelated Live-in Caregiver Supports**

Table 31.1 – Description of Billing and Reimbursement for Rent and Food for Unrelated Live-in Caregiver Supports

Procedure Code and Modifier	INsite Code	Procedure Code Description	Reimbursement/Unit Measurement Methodology	Waivers
T2025 U7	R&F	Waiver Services; not otherwise specified rent and food expenses for an unrelated live in caregiver	Based on an approved NOA Monthly rate	AU, DD

### **Service Definition**

Rent and Food for an Unrelated, Live-in Caregiver Supports means the additional cost an individual incurs for the room and board of an unrelated, live-in caregiver as provided for the individual's Residential Budget.

### **Allowable Activities**

- The individual receiving these services lives in his or her *own* home
- For payment to not be considered income for the individual receiving services, payment for the portion of the costs of rent and food attributable to an unrelated, live-in caregiver must be made directly to the live-in caregiver
- Room and board for the unrelated live-in caregiver (who is not receiving any other financial reimbursement for the provision of this service)
- Room: shelter type expenses including all property related costs such as rental or purchase of real estate and furnishings, maintenance, utilities and related administrative services
- Board: three meals a day or other full nutritional regimen
- Unrelated: unrelated by blood or marriage to any degree
- Caregiver: an individual providing a covered service as defined by BDDS service definitions or in a Medicaid HCBS waiver, to meet the physical, social or emotional needs of the individual receiving services

### **Activities Not Allowed**

- When the individual lives in the home of the caregiver or in a residence owned or leased by the provider of other services, including Medicaid waiver services
- When the live-in caregiver is related by blood or marriage (to any degree) to the individual

### **Service Standards**

- Rent and Food for an Unrelated Live-in Caregiver should be reflected in the Individualized Support Plan of the individual

- Services must address needs identified in the person centered planning process and be outlined in the Individualized Support Plan
- Services must complement other services the individual receives and enhance increasing independence for the individual
- The person centered planning team will decide and assure that the individual who will serve as a live-in caregiver has the experience, skills, training and knowledge appropriate to the individual and the type of support needed

### Documentation Standards

- Rent and Food for Unrelated Live-in Caregiver documentation must include:
- Identified in the Individualized Support Plan
- Documentation of how amount of Rent and Food was determined
- Receipt that funds were paid to the individual
- Documentation in compliance with 460 IAC 6

Table 31.2 – Provider Licensure and Certification Table for Rent and Food for Unrelated Live-in Caregiver Supports

Waiver	Provider	License	Certification	Other Standard
DD, AU	Agency – types: DDRS Approved Residential Habilitation and Support provider			DDRS-approved, 460 IAC 6-10-5 <i>Criminal Histories</i> , 460 IAC 6-5- 30 <i>Transportation</i> and 6-5-14 <i>Qualifications for RHS</i> , 460 IAC 6-14-5 <i>Direct Care Staff</i> <i>Qualifications</i> , 460 IAC 6-14-4 <i>Staff Training</i> , 460 IAC 6-5-23 <i>Rent/Food for Unrelated Live-In</i> <i>Caregiver Supports</i> provider qualifications
AU, DD	Individual – types: DDRS approved Residential Habilitation and Support provider			Same as above

## Section 32: Residential Habilitation - TBI

Table 32.1 – Description of Billing and Reimbursement for Residential Habilitation – TBI

Procedure Code and Modifier	INsite Code	Procedure Code Description	Reimbursement/Unit Measurement Methodology	Waivers
97535 U7	RBHA	Residential Habilitation; Self care/Home management training, direct contact by provider.	Based on an approved NOA One Unit = 15 minutes One Hour = 4 units	TBI

### Service Definition

Assistance with the acquisition, retention or improvement in skills related to activities of daily living, such as personal grooming and cleanliness, bed making and household chores, eating and the preparation of food, and the social and adaptive skills necessary to enable the individual to live in a non-institutional setting.

Transportation will be provided between the individual's place of residence and the site of the habilitative services (residential habilitation, day habilitation, supported employment), or between habilitation sites (in cases where the individual receives habilitation services in more than one place) as a component part of habilitation services. The cost of this transportation is included in the rate paid to providers of the appropriate type of habilitation services

### Activities Not Allowed

- Payments for residential habilitation are not made for room and board, the cost of facility maintenance, upkeep and improvement, other than such costs for modifications or adaptations to a facility required to assure the health and safety of residents, or to meet the requirements of the applicable life safety code.
- Payment for residential habilitation does not include payments made directly or indirectly to members of the individual's immediate family.
- Payments will not be made for the routine care and supervision which would be expected to be provided by a family or group home provider, or for activities or supervision for which payment is made by a source other than Medicaid.

### Documentation Standards

- Services outlined in Plan of Care/ Cost Comparison Budget (POC/CCB)
- A data record of staff to individual service documenting the names of both the staff and individual, the complete date and the start and stop time of the service (including a.m. or p.m.)
- Each staff that provides uninterrupted, continuous service in direct supervision or care of the individual must make one entry. If a staff member provided interrupted service (for example, one hour in the morning and one hour in the evening) an entry for each unique encounter must be made. All entries should describe an issue or circumstance concerning the individual.
- If the person providing the service is required to be professionally licensed, the title of the individual must also be included.

Table 32.2 – Provider Licensure and Certification Table for Residential Habilitation – TBI

Waiver	Provider	License	Certification	Other Standard
TBI	Community Developmental Disabilities Agencies	IC 12-7-2-39	CARF	DA-approved 460 IAC 1.2-6-2 General requirements, 460 IAC 1.2-6-3 General requirements for direct care staff, 460 IAC 1.2-13 Professional qualifications and requirements, 460 IAC 1.2-14 Personnel Records, 460 IAC 1.2-12-1 Transportation of an individual, DA approval requirements
TBI	Developmental Disabilities Residential Agencies	IC 12-11-1		
TBI	Rehab Facilities		CARF	Habilitation and rehabilitation services must be performed by persons who are supervised by a Qualified Mental Retardation Professional (QMRP) or a physical, occupational, or speech therapist licensed by the state of Indiana and has successfully completed training or has experience in conducting habilitation or rehabilitation programs.

## **Section 33: Residential Habilitation and Support Services**

Table 33.1 – Description of Billing and Reimbursement for Residential Habilitation and Support Services

Procedure Code and Modifier	INsite Code	Procedure Code Description	Reimbursement/Unit Measurement Methodology	Waivers
T2016 U7 U1	RHSS	Residential Habilitation and Supports	Based on an approved NOA Daily rate	AU, DD

### **Service Definition**

Residential Habilitation and Support service providers are responsible for the health, safety and welfare of the individual, and assist in the acquisition, improvement, and retention of skills necessary to support individuals to live successfully in their own homes.

### **Allowable Activities**

- Direct supervision, monitoring and training to implement the Individualized Support Plan (ISP) outcomes for the individual through the following:
- Assistance with personal care, meals, shopping, errands, chore and leisure activities and transportation (excluding transportation that is covered under the Medicaid State Plan)
- Coordination and facilitation of medical and non-medical services to meet healthcare needs, including physician consults, medications, development and oversight of a health plan, utilization of available supports in a cost effective manner and maintenance of each individual's health record
- Assurance that direct service staff are aware and active individuals in the development and implementation of ISP and Behavior Support Plans

### **Activities Not Allowed**

- Services furnished to a minor by the parent(s), step-parent(s), or legal guardian
- Services furnished to an individual by the person's spouse
- Services to individuals in Adult Foster Care or Children's Foster Care
- Services that are available under the Medicaid State Plan
- Services furnished to an adult individual by a parent, step-parent or guardian, that exceed 40 hours per week

### **Service Standards**

- Residential habilitation supports must be reflected in the Individualized Support Plan.
- Documentation in compliance with 460 IAC 6.

## Documentation Standards

Residential Habilitation and Support services documentation must include:

- Approved provider credentials
- Documentation for each day of service rendered. The specific data elements required for each day of service include the following:
  - Type and unit of service
  - Name of individual served
  - RID Number of the individual
  - Date of service (including the year)
  - Notation of the primary location at which the service was rendered
  - A description of an issue or circumstance concerning the individual made by direct care staff. The entry should include complete time and date of the entry (include a.m. or p.m.) and a signature that includes at least the last name and first initial of the direct care staff person making the entry. Electronic signatures are acceptable if the provider has a log on file that shows the staff member's electronic signature, their actual signature and their printed name. A minimum of one entry per shift is required.
- Documentation in compliance with 460 IAC 6

Clinical/Progress Documentation is also required and must include:

- The provider must complete a monthly summary of the individual's progress toward outcomes, using the approved form. This is a narrative summary, about one page in length, that describes the individual's residential habilitation supports activities, and must address outcomes in the individual's ISP, as well as a high level summary of issues affecting the health, safety and welfare of the individual requiring intervention by a healthcare professional, case manager, behavior support services provider or BDDS staff member.
- This documentation will be reviewed as part of the BQIS quality reviews. Failure to maintain these monthly summaries as described above will be considered a violation of the Medicaid provider agreement and reimbursement for services will not be available.

Table 33.2 – Provider Licensure and Certification Table for Residential Habilitation and Support Services

Waiver	Provider	License	Certification	Other Standard
DD, AU	Individual RHS – types: DDRS approved RHS individuals			DDRS-approved, 460 IAC 6-10-5 Criminal Histories, 460 IAC 6-12 Insurance, 460 IAC 6-11 Financial Status, 460 IAC 6-5-30 Transportation, 460 IAC 6-5-14 Qualification for RHS, 460 IAC 6-14-5 Direct Care Staff Qualifications, 460 IAC 6-14-4 Staff Training
DD, AU	RHS Agency – types: DDRS approved RHS Agencies			DDRS-approved, 460 IAC 6-10-5 Criminal Histories, 460 IAC 6-12, 460 IAC 6-11, 460 IAC 6-5-30 and 6-5-14 Qualifications for RHS, 460 IAC 6-14-5 Direct Care Staff Qualifications, 460 IAC 6-14-4 Staff Training, RN and LPN staff must meet IC 25-23

## Section 34: Respite Care Services

Table 34.1 – Description of Billing and Reimbursement for Respite Care Services

Procedure Code and Modifier	INsite Code	Procedure Code Description	Reimbursement/Unit Measurement Methodology	Waivers
T1005 U7 UA TD	RNUR	Respite care services, RN provided	Based on an approved NOA (1 unit = 15 minutes)	AD, AU, DD, SSW, TBI
T1005 U7 UA TE	RNUR	Respite care services, LPN provided	Based on an approved NOA (1 unit = 15 minutes)	AD, AU, DD, SSW, TBI
S5150 U7 HQ	GRES	Unskilled respite care, not hospice,	Based on an approved NOA (1 unit = 15 minutes)	AU, DD, SSW
S5150 U7 UA U9	RHHA	Unskilled respite care, not hospice,	Based on an approved NOA (1 unit = 15 minutes)	AD, AU, DD, SSW, TBI
S5150 U7 UA UB	RHMK	Unskilled respite care, not hospice, group setting	Based on an approved NOA (1 unit = 15 minutes)	AD, TBI
S5150 U7 UA UC	RATT	Unskilled respite care, not hospice, Personal Care Attendant, for Agency use	Based on an approved NOA (1 unit = 15 minutes)	AD, AU, DD, SSW, TBI
S5150 U7 UB	RATT	Unskilled respite care, not hospice, Homemaker, for Non-agency use	Based on an approved NOA (1 unit = 15 minutes)	AD, TBI
S5150 U7 UC	RATT	Unskilled respite care, not hospice, Personal Care Attendant, for Non-agency use	Based on an approved NOA (1 unit = 15 minutes)	AD, AU, DD, SSW, TBI

### Definition of Service

#### AD, TBI Waiver:

Respite Care services are those services that are provided temporarily or periodically in the absence of the usual caregiver. Service may be provided in the following locations: in an individual's home, in the private home of the caregiver, in an adult foster care home, or in a Medicaid certified nursing facility. Please note that for those individuals receiving the *service* of Adult Foster Care, funding for respite care is already included in the per diem amount and the actual service of Respite Care may not be billed.

The level of professional care provided under respite care services depends on the needs of the client.

- A client requiring assistance with bathing, meal preparation and planning, specialized feeding, such as a client who has difficulty swallowing, refuses to eat, or does not eat enough; dressing or undressing; hair and oral care; and weight bearing transfer assistance should be considered for respite home health aide under the supervision of a registered nurse.



- A client requiring infusion therapy; venipuncture; injection; oral medication; Hoyer lift; wound care for surgical, decubitus, incision, and so forth; ostomy care; and tube feedings should be considered for respite nursing services

**DD, AU, SSW Waiver:**

- Respite Care services means services provided to individuals unable to care for themselves that are furnished on a short-term basis because of the absence or need for relief of those persons normally providing care. Respite Care can be provided in the individual's home or place of residence, in the caregiver's home or in a non-private residential setting (such as a respite home).

**Allowable Activities**

**AD, TBI Waiver:**

- Homemaker services
- Attendant care
- Home health aide services
- Skilled nursing services
- Nursing facility services – The care manager is required to receive prior authorization from the Indiana Family and Social Services Administration (IFSSA) with a completed *Request for Approval to Authorize Services Form* before Respite Care may be provided in a nursing facility.

**DD, AU, SSW Waiver:**

- Assistance with toileting and feeding
- Assistance with daily living skills, including assistance with accessing the community and community activities
- Assistance with grooming and personal hygiene
- Meal preparation, serving and cleanup
- Administration of medications
- Supervision

**Activities Not Allowed**

- Respite care shall not be used as day/child care to allow the persons normally providing care to go to work.
- Respite care shall not be used as day/child care to allow the persons normally providing care to attend school.
- Respite care shall not be used to provide service to a member while member is attending school.
- Respite care may not be used to replace skilled nursing services that should be provided under the Medicaid State Plan
- Services provided by the parent of a minor child or the individual's spouse
- Respite care must not duplicate any other service being provided under the individual's POC/ISP.

**DD, AU, SSW Waiver:**

- Reimbursement for room and board

- Services provided to an individual living in a licensed facility based setting
- The cost of registration fees or the cost of recreational activities (for example, camp)
- When the service of Adult Foster Care or Children's Foster Care is being furnished to the individual

### **Service Standards**

- The level of care and type of respite care will not exceed the requirements of the plan of care. Therefore, skilled nursing services will only be provided when the needs of the client warrant skilled care. Other respite care such as attendant care will be provided by the appropriate provider when nursing services are not required.
- If an individual's needs can be met with an LPN, but an RN provides the service, the service may only be billed at the LPN rate, per Indiana Health Coverage Programs (IHCP) provider bulletin BT200371.

#### **DD, AU, SSW Waiver:**

- Respite care must be reflected in the Individualized Support Plan

### **Documentation Standards**

- Documentation must include the following elements: the reason for the respite, the location where the service was rendered and the type of respite rendered. For example, respite Home Health Agency (HHA).
- Data Record of staff to client service documenting the complete date and time in and time out, and the number of units of service delivered that day.
- Each staff member providing direct care or supervision of care to the client makes at least one entry on each day of service describing an issue or circumstance concerning the client.
- Documentation should include date and time, and at least the last name and first initial of the staff person making the entry. If the person providing the service is required to be a professional, the title of the individual must also be included. For example, if a nurse is required to perform the service then the RN title would be included with the name.
- Any significant issues involving the client requiring intervention by a health care professional, or case manager that involved the client also needs to be documented.

Table 34.2 – Provider Licensure and Certification Table for Respite Care Services

Waiver	Provider	License	Certification	Other Standard
AD, TBI,	Community Development Disabilities Agencies	<i>IC 12-7-2-39</i>	CARF	DA-approved 460 IAC 1.2-6-2 General requirements, 460 IAC 1.2-6-3 General requirements for direct care staff, 460 IAC 1.2-13 Professional qualifications and requirements, 460 IAC 1.2-14 Personnel Records, DA approval requirements
AD, TBI	Licensed Home Health Agencies	<i>IC 16-27-1</i> <i>410 IAC 17-2</i> Licensed by Indiana State Department of Health		Same as above
AD, TBI	Medicaid Certified Nursing Facility	<i>IC 16-28-2</i>		Same as above
AD, TBI	Individuals/ Family Members			
DD, AU, SSW	Home Health Agency – types: Licensed Home Health Agencies	Home Health Agency: <i>IC 16-27-1</i> , RN and LPN: <i>IC 25-23</i>	Home Health Aide Registered: <i>IC 16-27-1.5</i>	DDRS-approved
DD, AU, SSW	Respite Agency – types: DDRS approved Respite Agencies			DDRS-approved 460 IAC 6-10-5 Criminal Histories, 460 IAC 6-12 Insurance, 460 IAC 6-11 Financial Status, 460 IAC 6-5-14 Health Care Coordination Qualifications, 460 IAC 6-14-5 Direct Care Staff Qualifications, 460 IAC 6-14-4 Staff Training, BDDS Approval requirements
DD, AU, SSW	Individual Respite – types: DDRS approved Respite providers			Same as above
DD, Au, SSW	Individual Skilled nursing - types: DDRS approved Respite Agencies	<i>IC 25-23</i>		DDRS-approved, 460 IAC 6-10-5 Criminal Histories, 460 IAC 6-5-26, 460 IAC 6-5-14, 460 IAC 6-4-14 Staff Training, BDDS approval requirements

## Section 35: Specialized Medical Equipment and Supplies

Table 35.1 – Description of Billing and Reimbursement for Specialized Medical Equipment and Supplies

Procedure Code and Modifier	INsite Code	Procedure Code Description	Reimbursement/Unit Measurement Methodology	Waivers
T2029 U7 NU	ATCH	Specialized Medical Equipment, not otherwise specified; New	Based on an approved NOA and RFA	AD, AU, DD, SSW, TBI
T2029 U7 RP	ATCM	Specialized Medical Equipment, not otherwise specified; Replacement and Repair	Based on an approved NOA and RFA	AD, AU, DD, SSW, TBI
T2039 U7	VMOD	Vehicle Modification	Based on an Approved NOA and RFA	AD, AU, DD, SSW, TBI

### Service Definition

Specialized medical equipment and supplies to include devices, controls, or appliances, specified in the plan of care, which enable individuals to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live.

Waiver Services must approve all specialized medical equipment and supplies prior to service being rendered.

### Allowable Activities

- Items necessary for life support
- Adaptive equipment and supplies
- Ancillary supplies and equipment needed for the proper functioning of specialized medical equipment and supplies
- Durable medical equipment not available under Medicaid State Plan
- Non-durable medical equipment not available under Medicaid State Plan
- Vehicle Modifications

#### DD, AU, SSW

- Communications devices
- Interpreter services

### Activities Not Allowed

- Equipment and services that are available under the Medicaid State Plan
- Equipment and services that are not of direct medical or remedial benefit to the individual

- Equipment and services that are not included in the comprehensive plan of care
- Equipment and services that have not been approved on a Request for Approval to Authorize services (RFA)

**DD, AU, SSW**

- Equipment and services that are not reflected in the Individualized Support Plan
- Equipment and services that do not address needs identified in the person centered planning process

**Service Standards**

- Equipment and supplies must be of direct medical or remedial benefit to the individual
- All items shall meet applicable standards of manufacture, design and installation

**DD, AU, SSW**

- Any individual item costing over \$500 requires an evaluation by a qualified professional such as a physician, nurse, Occupational Therapist, Physical Therapist, Speech and Language Therapist or Rehabilitation Engineer
- Annual maintenance service is available and is limited to \$500 per year. If the need for maintenance exceeds \$500, the case manager will work with other available funding streams and community agencies to fulfill the need

**Documentation Standards**

- Identified need in POC/CCB.
- Identified direct medical benefit for the individual.
- Documentation of the request for IHCP prior approval (denied PA).
- Documentation of the reason of denial of IHCP prior authorization.
- Receipts for purchases.
- Signed and approved *Request for Approval to Authorize Services* (State Form 45750)

Table 35.2 – Provider Licensure and Certification Table for Specialized Medical Equipment and Supplies Services

Waiver	Provider	License	Certification	Other Standard
AD, TBI	Qualified Contractors Businesses Individuals Medical Supply Companies Pharmacies Electronics/Computer Companies Automotive Vehicle Specialists			DA-approved 460 IAC 1.2-6-2 General requirements, 460 IAC 1.2-6-3 General requirements for direct care staff, 460 IAC 1.2-13 Professional qualifications and requirements, 460 IAC 1.2-14 Personnel Records, DA approval requirements, 460 IAC 1.2-18-1 Warranty Required
AU, DD, SSW	Agency - types: DDRS approved providers: Medical Supply Companies Pharmacies Electronics/Computer vendors Vehicle Modification vendors			DDRS-approved, 460 IAC 6-10-5 Criminal Histories, 460 IAC 6-12 Insurance, 460 IAC 6-11 Financial Status of Provider, 460 IAC 6-5-27 Specialized Medical Equipment and Supplies Provider Qualifications

Table 35.2 – Provider Licensure and Certification Table for Specialized Medical Equipment and Supplies Services

<b>Waiver</b>	<b>Provider</b>	<b>License</b>	<b>Certification</b>	<b>Other Standard</b>
AU, DD, SSW	Individual – types: Physical Therapist, Occupational Therapist, Speech–Language	<i>PT IC 25-27-1</i> <i>SLT IC 25-35.6</i>		DDRS-approved, 460 IAC 6-10-5 <i>Criminal Histories</i> , 460 IAC 6-12, 460 IAC 6-11, 460 IAC 6-5-27
AU, DD, SSW	Home Health Agencies	<i>IC 26-27-2</i>		DDRS-approved, 460 IAC 6-10-5 <i>Criminal Histories</i> , 460 IAC 6-12, 460 IAC 6-11, 460 IAC 6-5-27

## Section 36: Speech-Language Therapy Services

Table 36.1 – Description of Billing and Reimbursement for Speech-Language Therapy Services

Procedure Code and Modifier	INsite Code	Procedure Code Description	Reimbursement/Unit Measurement Methodology	Waivers
92507 U7 UA	SPTH	Individual treatment of Speech, Language, Voice, Communication, and/or Auditory Processing Disorder	Based on an approved NOA One unit = 15 minutes	AU, DD, SSW, TBI

### Definition of Speech-Language Therapy Services

Speech-Language Therapy Services means services provided by a licensed speech pathologist under 460 IAC 6.

### Allowable Activities

- Screening
- Assessment
- Direct therapeutic intervention and treatment for speech and hearing disabilities such as delayed speech, stuttering, spastic speech, aphasic disorders, injuries, lip reading or signing, or the use of hearing aids.
- Evaluation and training services to improve the ability to use verbal or non-verbal communication.
- Language stimulation and correction of defects in voice, articulation, rate and rhythm.
- Design, fabrication, training and assistance with adaptive aids and devices.
- Consultation demonstration of techniques with other service providers and family members.
- Participating on the interdisciplinary team, when appropriate, for the development of the plan.

### Activities Not Allowed

- Reimbursement for time spent in planning, reporting and write-up
- Services available through the Medicaid State Plan (such as, a Medicaid State Plan prior authorization denial is required before reimbursement is available through the Medicaid waiver for this service).
- Activities delivered in a nursing facility.

### Service Standards

- Individual Speech-Language Therapy Services must be reflected in the Individualized Support Plan.
- To be eligible for this service, the individual must have been examined by a certified audiologist and/or a certified speech therapist who has recommended a formal speech/audiological program.



- The need for such services must be documented by an appropriate assessment and authorized in the individual's service plan.

### **Documentation Standards**

- Documentation of an appropriate assessment
- Services outlined in the Individualized Support Plan
- BDDS approved provider
- Appropriate credentials for service provider
- Attendance record, therapist logs and/or chart detailing service provided, date and times.
- Documentation in compliance with 460 IAC 6

Table 36.2 – Provider Licensure and Certification Table for Speech-Language Therapy Services

<b>Waiver</b>	<b>Provider</b>	<b>License</b>	<b>Certification</b>	<b>Other Standard</b>
AU, DD, SSW	Agency – types: Home Health Agencies, Therapy Agencies	IC 16-27-1		DDRS-approved, 460 IAC 6-10-3 Criminal Histories, 460 IAC 6-12 Insurance, 460 IAC 6-11 Financial Status of Provider, 460 IAC 6 -5-28 Speech-Language Therapy Provider Qualifications, BDDS approval requirements
AU, DD, SSW	Individual – types: Licensed Speech/Language Therapist and Qualified Paraprofessional	Speech-Language Therapist: IC 25-35.6	Speech Language Therapy Aid: IC 25-35.6-1-2, 880 IAC 1-2.1 Speech Language Therapy Assistant: IC 25-35.6	DDRS-approved, 460 IAC 6-10-5 Criminal Histories, 460 IAC 6-12, 460 IAC 6-11, 460 IAC 6-5-28, BDDS approval requirements
TBI	Same as above	Same as above	Same as above	DA-approved 460 IAC 1.2-6-2 General requirements, 460 IAC 1.2-6-3 General requirements for direct care staff, 460 IAC 1.2-13 Professional qualifications and requirements, 460 IAC 1.2-14 Personnel Records, DA approval requirements

## Section 37: Supported Employment

Table 37.1 – Description of Supported Employment Services

Procedure Code and Modifier	INsite Code	Procedure Code Description	Reimbursement/Unit Measurement Methodology	Waivers
H2023 U7		Supported Employment Per 15 minutes	Based on an Approved NOA One Unit = 15 minutes	TBI

### Service Definition

Supported Employment services consist of paid employment for persons for whom competitive employment at or above the minimum wage is unlikely, and who, because of their disabilities, need intensive ongoing support to perform in a work setting. Supported Employment is conducted in a variety of settings, particularly work sites where persons without disabilities are employed. Supported Employment includes activities needed to sustain paid work by individuals receiving waiver services, including supervision and training.

### Service Standards

- When Supported Employment services are provide at a worksite where persons without disabilities are employed, payment will only be made for the adaptation, supervision and training required by individuals receiving waiver services as a result of their disabilities and will not include payment for the supervisory activities rendered as a normal part of the business setting
- Supported Employment services furnished under the waiver must be services which are not available under a program funded by either the Rehabilitation Act of 1973 or P.L. 94-142. Documentation will be maintained in the file of each individual receiving this service showing that:
  1. The service is not otherwise available under a program funded under the Rehabilitation Act of 1973 or P.L. 94-142
- Reimbursement will not be paid for claims for incentive payments, subsidies, or unrelated vocational training expenses such as the following:
  1. Incentive payments made to an employer to encourage or subsidize the employers participation in a Supported Employment program;
  2. Payments that are passed through to users of Supported Employment programs; or
  3. Payments for vocational training that is not directly related to an individual's employment program
- Transportation will be provided between the individual's place of residence and the site of the habilitative services residential habilitation, day habilitation, supported employment), or between habilitation sites (in cases where the individual receives habilitation services in more than one place) as a component part of habilitation services. The cost of this transportation is included in the rate paid to providers of the appropriate type of habilitation services

### Documentation Standards

- Services outlined in Plan of Care/ Cost Comparison Budget (POC/CCB)
- A data record of staff to individual service documenting the names of both the staff and individual, the complete date and the start and stop time of the service (including a.m. or p.m.)

- Each staff that provides uninterrupted, continuous service in direct supervision or care of the individual must make one entry. If a staff member provided interrupted service (for example, one hour in the morning and one hour in the evening) an entry for each unique encounter must be made. All entries should describe an issue or circumstance concerning the individual.
- If the person providing the service is required to be professionally licensed, the title of the individual must also be included.

Table 37.2 – Provider Licensure and Certification Table for Supported Employment Services

Waiver	Provider	License	Certification	Other Standard
TBI	Community Developmental Disabilities Agencies	12-7-2-39	CARF	DA-approved 460 IAC 1.2-6-2 General requirements, 460 IAC 1.2-6-3 General requirements for direct care staff, 460 IAC 1.2-13 Professional qualifications and requirements, 460 IAC 1.2-14 Personnel Records, 460 IAC 1.2-12-1 Transportation of an individual, DA approval requirements
TBI	Community Mental Health Centers	12-7-2-38		Same as above

## Section 38: Therapy Services (Psychological)

Table 38.1 – Description of Billing and Reimbursement for Therapy Service (Psychological)

Procedure Code and Modifier	INsite Code	Procedure Code Description	Reimbursement/Unit Measurement Methodology	Waivers
90804 U7	PSTI	Individual psychotherapy, face to face, in an office or outpatient facility, with medical evaluation & management services, approx. 75-80 minutes	Based on an approved NOA One unit = 15 minutes	AU, DD, SSW
90846 U7	PSTF	Family medical psychotherapy (without the client present)	Based on an approved NOA One unit = 15 minutes	AU, DD, SSW
90853 U7	PSTG	Psychological Therapy - Group per 15 minute units	Based on an approved NOA One unit = 15 minutes	AU, DD, SSW

### Service Definition

Therapy Services means services provided under 460 IAC 6-3-56 by a licensed psychologist with an endorsement as a health service provider in psychology, a licensed marriage and family therapist, a licensed clinical social worker, or a licensed mental health counselor.

### Allowable Activities

- Individual counseling
- Biofeedback
- Individual-centered therapy
- Cognitive behavioral therapy
- Psychiatric services
- Crisis counseling
- Family counseling
- Group counseling
- Substance abuse counseling and intervention

### Activities Not Allowed

- Reimbursement is not available for Therapy Services when services are reimbursable through the Medicaid State Plan.

### Service Standards

- Therapy Services should be reflected in the Individualized Support Plan of the individual.

- Services must address needs identified in the person centered planning process and be outlined in the Individualized Support Plan
- Services must complement other services the individual receives and enhance increasing independence for the individual

### Documentation Standards

- Documentation by appropriate assessment
- Services outlined in the Individualized Support Plan
- Appropriate credentials for service provider
- Attendance record, therapist logs and/or chart detailing service provided, date and times
- Documentation in compliance with 460 IAC 6

Table 38.2 – Provider Licensure and Certification Table for Therapy Service (Psychological)

Waiver	Provider	License	Certification	Other Standard
AU, DD, SSW	Individual – types: Licensed Psychologist, Marriage/Family Therapist, Clinical Social Worker, Mental Health Counselor	Psychologist: <i>IC 25-33-1-5.1</i>  Marriage and Family Therapist: <i>IC 25-23-6</i>  Clinical Social Worker: <i>IC 25-23.6</i>  Mental Health Counselor: <i>IC 25-23.6</i>		DDRS-approved, 460 IAC 6-10-5 <i>Criminal Histories</i> , 460 IAC 6-12 <i>Insurance</i> , 460 IAC 6-11 <i>Financial</i> <i>Status of Provider</i> , 460 IAC 6-5-21 <i>(Psychological) Therapy Provider</i> <i>Qualifications</i> , BDDS approval <i>requirements</i>
AU, DD, SSW	Agency – types: DDRS approved qualified agencies			Same as above

## Section 39: Transportation

Table 39.1 – Description of Billing and Reimbursement for Transportation services

Procedure Code and Modifier	INsite Code	Procedure Code Description	Reimbursement/Unit Measurement Methodology	Waivers
T2004 U7 U1		Non-Emergency Transport-Commercial Carrier, Multi-Pass, U1=Non-Assisted	Based on an approved NOA Per Service Fee	TBI
T2004 U7 U2		Non Emergency Transport-Commercial Carrier, Multi-Pass, U2=Assisted	Based on an approved NOA Per Service Fee	TBI

### Service Definition

Services offered in order to enable individuals served under the waiver to gain access to waiver and other community services, activities and resources, specified by the plan of care

### Service Standards

- This service is offered in addition to medical transportation required under 42 CFR 431.53 and transportation services under the State plan, defined at 42 CFR 440.170(a) (if applicable), and shall not replace them.
- Transportation services under the waiver shall be offered in accordance with an individual's plan of care.
- Whenever possible, family, neighbors, friends, or community agencies which can provide this service without charge will be utilized
- Transportation services are reimbursed at two (2) levels of service:
  1. Level 1 Transportation – the individual does not require mechanical assistance to transfer in and out of the vehicle
  2. Level 2 Transportation – the individual requires mechanical assistance to transfer into and out of the vehicle

### Documentation Standards

- A provider or its agent shall maintain documentation that the provider meets and maintains the requirements for providing services under 460 IAC 1.2.

Table 39.2 – Provider Licensure and Certification Table for Transportation services

Waiver	Provider	License	Certification	Other Standard
AD, TBI	Community Developmental Disabilities Agencies Licensed Medicaid Certified Home Health Agencies DA approved Agencies	<i>IC 16-27-1-3</i> <i>410 IAC 17-2</i> <i>IC 16-13-22</i>	CARF	DA-approved <i>460 IAC 1.2-6-2</i> <i>General requirements, 460 IAC</i> <i>1.2-6-3 General requirements for</i> <i>direct care staff, 460 IAC 1.2-13</i> <i>Professional qualifications and</i> <i>requirements, 460 IAC 1.2-12-1</i> <i>Transportation of an individual,</i> <i>460 IAC 1.2-14 Personnel</i> <i>Records, DA approval</i> <i>requirements</i>

## **Section 40: Health Record and Legal Documentation Help**

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### **Legal Documentation Standards**

This section will review the legal documentation standards for entries in and maintaining health records. In today's health care environment health information is collected in various formats – paper-based, electronic resident records, and computerized resident databases. The legal documentation standards have mainly applied to a paper health record, however, most are also applicable to documentation in an electronic health record as well. This section is divided into four topics and will address the following issues:

1. Purpose of the legal health record.
2. Definition of the legal health record.
3. Legal documentation standards that apply to health records.
4. Proper methods for handling errors, omissions, addendum, and late entries.

### **Purpose of the Legal Health Record**

An individual's health record plays many important roles. The following list emphasizes key components of the legal health record:

1. It provides a view of the individual's health history - In other words, it provides, a record of the individual's health status including observations, measurements, history and prognosis, and serves as the legal document describing the health care services provided to the individual. The health record provides evidence of the quality of individual care by:
  - Describing the services provided to the individual
  - Providing evidence that the care was necessary
  - Documenting the individual's response to the care and changes made to the plan of care
  - Identifying the standards by which care was delivered
  - Documenting adherence to company standards and procedures
2. It provides a method for clinical communication and care planning among the individual healthcare practitioners serving the individual.
3. It provides supporting documentation for the reimbursement of services provided to the individual.
4. It is a source of data for clinical, health services, outcomes research as well as public health purposes.
5. It serves as a major resource for healthcare practitioner education.
6. It serves as the legal business record for a care organization and is used in support of business decision-making.

There is not a one-size-fits-all definition of the legal record since laws and regulations governing the content vary by practice setting and by state. However, there are common principles to be followed in creating a definition. The information that follows breaks down the health record into definable categories to provide guidelines for assisting care organizations in defining the content of their legal record.



## Definition of the Legal Health Record

- *Legal Health Record:* The legal business record generated at or for a care organization. This record would be released upon request. The following is a list of examples of documentation found in a legal health record:
  - Records of history and physical examination
  - Multidisciplinary progress notes and documentation
  - Immunization record
  - Problem list
  - Medication profile or Physician Orders and Renewals
  - Consent for treatment forms
  - Consultation reports
  - Physical therapy, Speech therapy, and Occupational therapy records
  - Email containing individual to provider or provider to provider communication
  - Graphic records
  - Intake/output records
  - Nursing and other discipline assessment
  - Care plan
  - Practice guidelines or protocols or clinical pathways that imbed an individual's data
  - Telephone orders
  - Advanced Directives
  - Discharge instructions, plan of care, etc
- *An Individual's Identifiable Source Data:* An adjunct component of the legal business record as defined by the organization. Often maintained in a separate location or database, these secondary records are provided the same level of confidentiality as the legal business record. The information is usually retrievable upon request. Examples of patient-identifiable source data:
  - Audio of dictation
  - Analog and digital patient photographs for identification purposes only
- *Administrative Data:* Provided the same level of confidentiality as the legal health record, however, the data is not considered part of the legal health record (such as in response to a subpoena for the "medical record.") Examples of administrative data:
  - Authorization forms for release of information
  - Correspondence concerning requests for records
  - Event history and audit trails
  - Protocols and clinical pathways, practice guidelines and other knowledge sources that do not imbed patient data
  - Individual-identifiable claim Individual-identifiable data reviewed for quality assurance or utilization management

## Legal Documentation Standards that Apply to Health Records:

- *Individual Name:* The individual's name must be on every page including both sides of the pages, every shingled form, computerized print out, etc. When double-sided forms are used, the individual's name should be on both sides since information is often copied and must be identifiable to the individual. Forms both paper and computer generated with multiple pages must also have the individual's name on all pages.
- *Date and Time on Entries:* Every entry in the health record must include a complete date – month, day and year and have a time associated with it. Time must be included in all types of narrative notes even if it may not seem important to the type of entry – it is a good legal standard to follow. Narrative documentation should reflect the actual time the entry was made. For certain types of

flow sheets such as a treatment record, recording time as a block could be acceptable. For example, a treatment that can be delivered any time during a shift could have a block of time identified on the treatment record with staff signing that they delivered the treatment during that shift.

- *Timeliness of Entries:* Entries should be made as soon as possible after an event or observation is made. An entry should never be made in advance. If it is necessary to summarize events that occurred over a period of time (such as a shift), the notation should indicate the actual time the entry was made with the narrative documentation identifying the time events occurred if time is pertinent to the situation..
- *Pre-dating and Backdating:* It is both unethical and illegal to pre-date or back-date an entry. Entries must be dated for the date and time the entry is made. (See section on late entries, addendum, and clarifications). If pre-dating or back-dating occurs it is critical that the underlying reason be identified to determine whether there are system failures. The cause must be evaluated and appropriate corrective action implemented.
- *Authentication of Entries and Methods of Authentication:* Every entry in the health record must be authenticated by the author – an entry should not be made or signed by someone other than the author. This includes all types of entries such as narrative/progress notes, assessments, flow sheets, orders, etc. whether in paper or electronic format. There are various acceptable methods for authentication of an entry. Each facility must identify the proper and acceptable method of authentication for the type of entry taking into consideration state regulations and payer requirements.
- *Signature:* Entries are typically authenticated by a signature. At a minimum the signature should include the first initial, last name and title/credential. Provider policies should define the acceptable format for signatures in the medical record.
- *Initials:* Any time a provider chooses to use initials in any part of the record for authentication of an entry there has to be corresponding full identification of the initials on the same form or on a signature legend. Initials can be used to authenticate entries such as flow sheets, medication records or treatment records, but should not be used in such entries as narrative notes or assessments. Initials should never be used where a signature is required by law.
- *Fax Signatures:* The acceptance of fax signatures is dependent on state, federal, and reimbursement regulations. Unless specifically prohibited by state regulations or facility policy, fax signatures are acceptable. When a fax document/signature is included in the health record, the document with the original signature should be retrievable.
- *Electronic/ Digital Signatures:* Electronic signatures are acceptable if allowed by state, federal, and reimbursement regulations. State regulations and payer policies must be reviewed to assure acceptability of electronic signatures when developing facility policies.
  - If electronic signatures are used in the health record, the software program/technology should provide assurance that the following standards are met:
    - *Message Integrity:* The message sent or entry made by a user is the same as the one received or maintained in the system.
    - *Non-Repudiation:* Assurance that the entry or message came from a particular user. It will be difficult for a party to deny the content of an entry or creating it.
    - *Authentication:* Confirms the identity of the user and verifies that a person really is who he says he is.
- *Rubber Stamp Signatures:* Rubber stamp signatures are acceptable if allowed by state, federal and reimbursement regulations. From a reimbursement perspective, some fiscal intermediaries have local policies prohibiting the use of rubber stamp signatures in the health record even though federal regulation allows for their use. Provider policies should define if rubber stamp signatures

are acceptable and define the circumstances for their use after review of state regulations and payer policies.

- *Signature Legend:* A signature legend may be used to identify the author and full signature when initials are used to authenticate entries. Each author who initials an entry must have a corresponding full signature on record.
- *Permanency of Entries:* All entries in the health record regardless of form or format must be permanent (manual or computerized records). For hard copy/paper records providers should document in blue or black ink only. No other colored ink should be used in the event that any part of the record needs to be copied. The ink should be permanent (no erasable or water-soluble ink should be used). Never use a pencil to document in the health record.
- *Specificity:* In writing entries use language that is specific rather than vague or generalized. Do not speculate when documenting -- the record should always reflect factual information (what is known vs. what is thought or presumed) and be written using factual statements. Examples of generalizations or vague words: Individual doing well appears to be, confused, anxious, status quo, stable, as usual.
- *Objectivity:* Chart the facts and avoid the use of personal opinions when documenting. By documenting what can be seen, heard, touched and smelled entries will be specific and objective. Describe signs and symptoms, use quotation marks to quote the resident, and document the resident's response to care.
- *Completeness:* Document all facts and pertinent information related to an event, course of treatment, resident condition, response to care and deviation from standard treatment (including the reason for it). Make sure entry is complete and contains all significant information. If the original entry is incomplete, follow guidelines for making a late entry, addendum or clarification.
- *Use of Abbreviations:* Every provider should set a standard for acceptable abbreviations to be used in the health record (develop a provider-specific abbreviation list). Only those abbreviations approved by the provider should be used in the health record. When there is more than one meaning for an approved abbreviation, providers chose one meaning or identify the context in which the abbreviation is to be used.
- *Legibility:* All entries in the health record must be legible. Illegible documentation can put the individual at risk. Readable documentation assists other caregivers and helps to assure continuation of the individual's plan of care. If entry cannot be read, the author should rewrite the entry on next available line, define what the entry is for referring back to the original documentation and legibly rewrite the entry. Example: "Clarified entry of (date)" and rewrite entry, date and sign. The entry rewritten must be the same as the original.
- *Continuous Entries:* In manual records, document entries on the next available space – do not skip lines or leave blanks. There must be a continuous flow of information without gaps or extra space between documentation. A new form should not be started until all previous lines are filled. If a new sheet was started, the lines available on the previous page must be crossed off. If an entry is made out of chronological order it should be documented as a late entry.
- *Completing all Fields:* Some of the questions or fields on documentation tools such as assessments, flow sheets, s and checklist documents may not all be applicable to the client. All fields should have some entry made whether it applies to the individual or not. If a field is not applicable, an entry like "N/A" should be made to show that the question was reviewed and answered. Fields left blank may be suspect to tampering or back-dating after the document has been completed and authenticated. If the documentation will be reported by exception (such as documenting only on shifts where a behavior occurs), there should be a statement on the form indicating how charting will be completed.
- *Continuity of Entries: Avoiding Contradictions:* All entries should be consistent with the concurrent entries and other parts of the health record (the assessments, care plan, physician's orders,

medication, etc.). Ongoing treatments and conditions (feeding tube, vent, trach, catheter, etc.) should be noted as continuing. Avoid repetitive (copy cat or parrot) charting. The current entry should document current observations, outcomes or progress. If an entry is made that contradicts previous documentation, the new entry should elaborate or explain why there is a contradiction or why there has been a change.

- *Condition Changes:* Every change in an individual's condition or significant individual care issues must be noted and charted until the individual's condition is stabilized or the situation is otherwise resolved. Documentation that provides evidence of follow-through is critical.
- *Document Informed Consent:* Informed consent should be carefully documented whenever applicable. An informed consent entry should include an explanation of the risks and benefits of a treatment/procedure, alternatives to the treatment or procedure, and evidence that the individual or appropriate legal surrogate understands and consents to undergo the treatment or procedure.
- *Incidents:* When an incident occurs, document the facts of the occurrence in the progress notes. Do not chart that an incident report has been completed or refer to the report in charting.
- *Make and Sign Own Entries:* Authors must always make and sign their own entries (both manual and computerized records). An author should never make an entry or sign an entry for someone else or have someone else make or sign an entry for them.
- *Appropriateness of Entries: Keep Documentation Relevant to Individual Care:* The health record should only contain documentation that pertains to the direct care of the individual. Do not let emotions show up in charting. Charting should be free from jousting statements that blame, accuse, or compromise other care givers, the individual, or his/her family. The health record should be a compilation of factual and objective information about the individual. The record should not be used to voice complaints (about other care givers, departments, physicians or the provider, family fights, fights between disciplines, gripes, staffing issues, vendor issues, etc.),

## Legal Guidelines for Handling Corrections, Errors, Omissions, and other Documentation Problems

There will be times when documentation problems or mistakes occur and changes or clarifications will be necessary. Proper procedures must be followed in handling Error Corrections. When an error is made in a health record entry, proper error correction procedures must be made as follows:

- Draw a line through entry (thin pen line). Make sure that the inaccurate information is still legible.
- Initial and date the entry.
- State the reason for the error (for example, in the margin or above the note if room)
- Document the correct information.
- Do not obliterate or otherwise alter the original entry by blacking out with marker, using white out, writing over an entry, etc.

Correcting an error in electronic or computerized health record systems should follow the same basic principles. The system must have the ability to track corrections or changes to the entry once the entry has been entered or authenticated. When correcting or making a change to an entry in a computerized health record system, the original entry should be viewable, the current date and time should be entered, the person making the change should be identified, and the reason should be noted. In situations where there is a hard copy printed from the electronic record, the hard copy must also be corrected.

- *Handling Omissions in Documentation:* At times, it will be necessary to make an entry that is late (out of sequence) or provide additional documentation to supplement entries previously written.

- *Making a late entry:* When a pertinent entry was missed or not written in a timely manner, a late entry should be used to record the information in the medical record.
  - Identify the new entry as a **late entry**
  - Enter the current date and time – do not try to give the appearance that the entry was made on a previous date or an earlier time.
  - Identify or refer to the date and incident for which late entry is written
  - If the late entry is used to document an omission, validate the source of additional information as much as possible (where did you get information to write late entry). For example, use of supporting documentation on other facility worksheets or forms.
  - When using late entries document as soon as possible. There is not a time limit to writing a late entry; however, the more time that passes the less reliable the entry becomes.

*Entering an Addendum:* An addendum is another type of late entry that is used to provide additional information in conjunction with a previous entry. With this type of correction, a previous note has been made and the addendum provides additional information to address a specific situation or incident. With an addendum, additional information is provided, but would not be used to document information that was forgotten or written in error. When making an addendum:

- Document the current date and time.
- Write **addendum**, and state the reason for the addendum referring back to the original entry.
- Identify any sources of information used to support the addendum.
- When writing an addendum, complete it as soon after the original note as possible.

*Entering a Clarification:* Another type of late entry is the use of a clarification note. A clarification is written to avoid incorrect interpretation of information that has been previously documented. For example, after reading an entry, there is a concern that the entry could be misinterpreted. To make a clarification entry:

- Document the current date and time.
- Write **clarification**, state the reason, and refer back to the entry being clarified.
- Identify any sources of information used to support the clarification.
- When writing a clarification note, complete it as soon after the original entry as possible.

## Section 41: Provider Help

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### INsite Communication Instructions

Listed below are the steps to obtain communications from INsite.

- Click on **Release Notes** from the main screen.
- Click on **Manuals, Bulletins, Procedures**.
- Choose the manual to view, then look at the entire table of contents (double-click on the manual title), an index, or perform a search.

### Helpful Web Sites

- <http://www.in.gov/fssa> - Find information by type of person in need: children, seniors, families, DD, and so forth. All programs and services available are listed on this site.
- <http://www.in.gov/fssa/servicedisabl> - Find listings for AAAs, BDDS offices, Voc Rehab, and other DD related information
- <http://www.in.gov/fssa/servicedisabl/bqis> - Find incident reporting information, provider standards, and other quality related information.
- <http://www.indianamedicaid.com> - Find IHCP provider bulletins, monthly provider newsletters, and the *IHCP Provider Manual*. Telephone contact information for providers is also available on this Web site.
- <http://www.in.gov/fssa/elderly/options/>

### Helpful Contact Numbers

- The Division of Disability and Rehabilitative Services at 1-800-545-7763
- The Division of Aging at 1-800-545-7763

## Area Agency on Aging Offices

### 16 Area Agencies



**AREA 1**  
**Area 1 Agency on Aging**  
**Northwest Indiana Community Action Corp.**  
 5518 Calumet Ave.  
 Hammond, IN 46320  
 (219) 937-3500 or (800) 826-7871  
 FAX (219) 932-0560 or (219) 931-5501  
 Web Site: [www.nw-ca.org](http://www.nw-ca.org)

**AREA 2**  
**REAL Services, Inc.**  
 1151 S. Michigan St., P.O. Box 1835  
 South Bend, IN 46634-1835  
 (574) 233-8205 or (800) 552-2916  
 FAX (574) 284-2642  
 Web Site: [www.realservices.com](http://www.realservices.com)

**AREA 3**  
**Aging and In-Home Services of**  
**Northeast Indiana, Inc.**  
 2729 Lake Avenue  
 Fort Wayne, IN 46805-5414  
 (260) 745-1200 or (800) 552-3662  
 FAX (260) 456-1066  
 Web Site: [www.agingihs.org](http://www.agingihs.org)

**AREA 4**  
**Area IV Agency on Aging & Community**  
**Action Programs, Inc.**  
 660 North 36th St., P.O. Box 4727  
 Lafayette, IN 47903-4727  
 (765) 447-7683 or (800) 382-7556  
 TDD (765) 447-3307; FAX (765) 447-6862  
 Web Site: [www.areaivagency.org](http://www.areaivagency.org)

**AREA 5**  
**Area Five Agency on Aging & Community**  
**Services, Inc.**  
 1801 Smith Street, Suite 300  
 Logansport, IN 46947-1577  
 (574) 722-4451 or (800) 654-9421  
 FAX (574) 722-3447  
 Web Site: [www.areafive.com](http://www.areafive.com)

**AREA 6**  
**LifeStream Services, Inc.**  
 1701 Pilgrim Blvd., P.O. Box 308  
 Yorktown, IN 47396-0308  
 (765) 759-1121 or (800) 589-1121  
 TDD (800) 589-1121; FAX (765) 759-0060  
 Web Site: [www.lifestreaminc.org](http://www.lifestreaminc.org)

**AREA 7**  
**Area 7 Agency on Aging and Disabled**  
**West Central Indiana Economic Development**  
**District, Inc.**  
 1718 Wabash Ave., P.O. Box 359  
 Terre Haute, IN 47803-0359  
 (812) 238-1561 or (800) 489-1561  
 TDD (800) 489-1561; FAX (812) 238-1564

**AREA 8**  
**CICOA In-Home Solutions**  
 4755 Kingsway Dr., Suite 200  
 Indianapolis, IN 46205-1560  
 (317) 254-5465 or (800) 489-9550  
 FAX (317) 254-5494; TDD (317) 254-5497  
 Web Site: [www.cicoa.org](http://www.cicoa.org)

**AREA 9**  
**Area 9 In-Home & Community**  
**Services Agency**  
 520 South 9th St., Suite 100  
 Richmond, IN 47374-6230  
 (765) 966-1795, (765) 973-8334 or  
 (800) 458-9345  
 FAX (765) 962-1190  
 Web Site: [www.iuc.indiana.edu/departments/Area 9](http://www.iuc.indiana.edu/departments/Area 9)

**AREA 10**  
**Area 10 Agency on Aging**  
 7500 W. Reeves Road  
 Bloomington, IN 47404  
 (812) 876-3383 or (800) 844-1010  
 FAX (812) 876-9922  
 Web Site: [www.area10.bloomington.in.us](http://www.area10.bloomington.in.us)

**AREA 11**  
**Aging & Community Services of**  
**South Central Indiana, Inc.**  
 1531 13th Street, Suite G-900  
 Columbus, IN 47201-1302  
 (812) 372-6918 or (866) 644-6407  
 FAX (812) 372-7846

**AREA 12**  
**LifeTime Resources, Inc.**  
 13091 Benedict Drive  
 Dillsboro, IN 47018  
 (812) 432-5215 or (800) 742-5001  
 FAX (812) 432-3822  
 Web Site: [www.lifetime-resources.org](http://www.lifetime-resources.org)

**AREA 13**  
**Generations**  
**Vincennes University Statewide Services**  
 P.O. Box 314  
 Vincennes, IN 47591  
 (812) 888-4292 or (800) 742-9002  
 TDD (812) 888-5762; FAX (812) 888-4566  
 Web Site: [www.generationsnetwork.org](http://www.generationsnetwork.org)

**AREA 14**  
**LifeSpan Resources, Inc.**  
 P.O. Box 995, 426 Bank Street  
 New Albany, IN 47151-0995  
 (812) 948-8330; FAX (812) 948-0147  
 Web Site: [www.lsr14.org](http://www.lsr14.org)

**AREA 15**  
**Hoosier Uplands/Area 15 Agency on Aging**  
**and Disability Services**  
 521 West Main Street  
 Mitchell, IN 47446  
 (812) 849-4457 or (800) 333-2451  
 TDD (800) 743-3333; FAX (812) 849-4467  
 Web Site: [www.hoosieruplands.org](http://www.hoosieruplands.org)

**AREA 16**  
**Southwestern Indiana Regional**  
**Council on Aging, Inc.**  
 16 W. Virginia St., P.O. Box 3938  
 Evansville, IN 47737-3938  
 (812) 464-7800 or (800) 253-2188  
 FAX (812) 464-7843 or (812) 464-7811  
 Web Site: [www.swirca.org](http://www.swirca.org)

To contact your local Area Agency toll-free, call  
**1-800-986-3505**

## Bureau of Developmental Disabilities Services Offices

### Central Office

Indianapolis  
P.O. Box 7083 MS #18  
Indianapolis, IN 46207-7083  
(317) 232-7842  
Fax: (317) 234-2099

### District 1

Merrillville  
5800 Broadway, Suite P  
Merrillville, IN 46410  
(219) 887-0503  
(877) 218-3053  
Fax: (219) 985-8652

### District 2

South Bend  
4634 W. Western Ave.  
South Bend, IN 46619-2304  
(574) 232-1412  
(877) 218-3059  
Fax: (574) 287-5482

### District 3

Fort Wayne  
219 W. Wayne St.  
Fort Wayne, IN 46802  
(260) 423-2571  
(877) 218-3061  
Fax: (260) 424-2830

### District 4

Greencastle  
1007 Mill Pond Rd., Suite A  
Greencastle, IN 46135  
(765) 653-2468  
(877) 218-3096  
Fax: (765) 653-7152

### District 5

Indianapolis  
4701 N. Keystone, Suite 427  
Indianapolis, IN 46205-1541  
(317) 254-2065  
(877) 218-3530  
Fax: (317) 254-2075

### District 6

Muncie  
1100 Martin Luther  
King Blvd, Suite 4  
Muncie, IN 47304  
(765) 288-6516  
(877) 218-3531  
Fax: (765) 288-8529

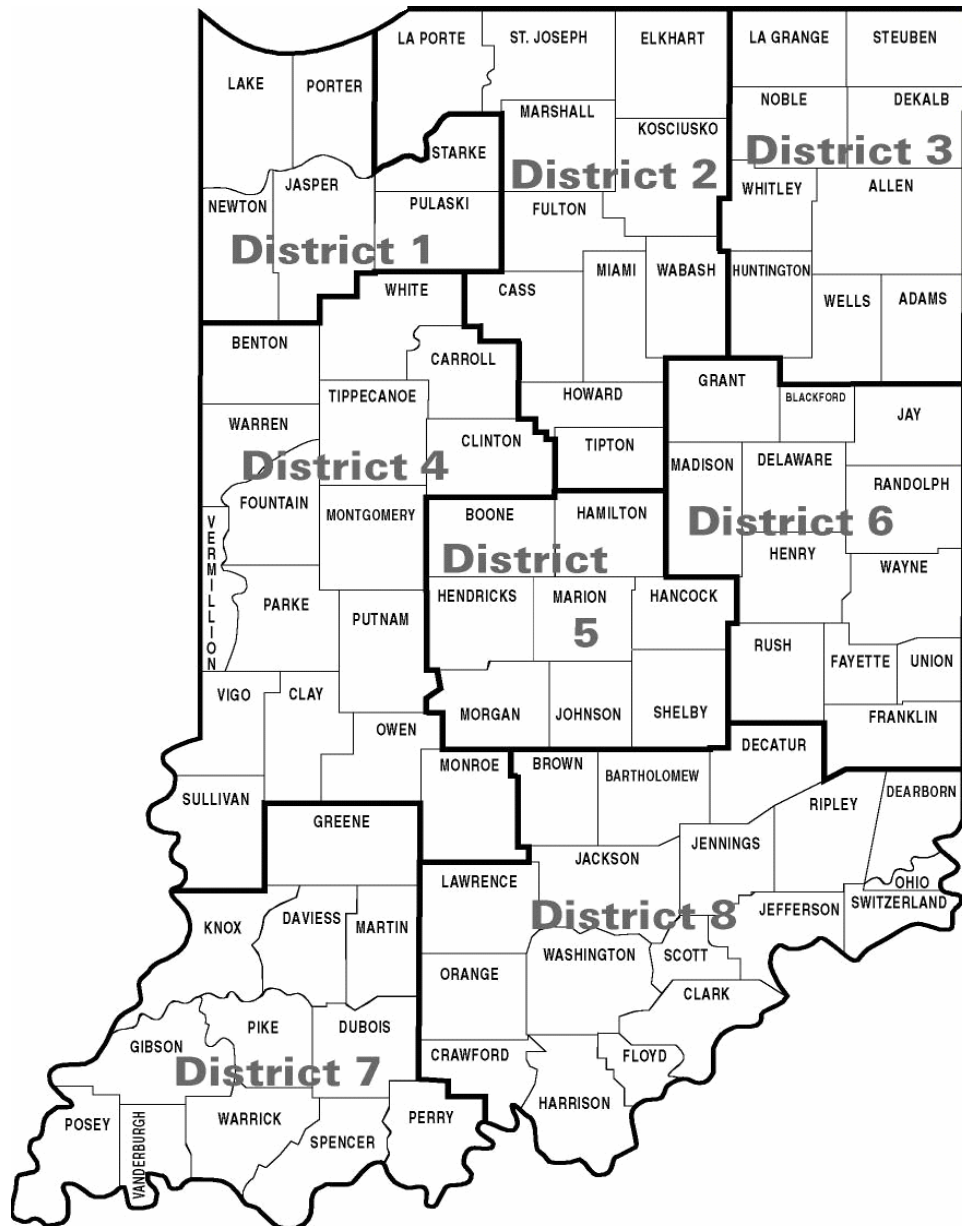
### District 7

Evansville  
700 E. Walnut St.  
Evansville, IN 47713  
(812) 423-8449  
(877) 218-3528  
Fax: (765) 288-8529

### District 8

Clarksville  
P.O. Box 2517  
1452 Vaxter Ave  
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## **Communications**

### ***General Information***

The Indiana Health Coverage Programs (IHCP) publishes the following communications to providers by mail and posting to the IHCP Web site at [www.indianamedicaid.com](http://www.indianamedicaid.com):

- IHCP provider bulletins
- IHCP banner pages (published each week and mailed with the provider remittance advice)
- IHCP monthly newsletters

Providers may also subscribe to the E-mail Notification Service on the IHCP Web site at [http://www.indianamedicaid.com/ihcp/mailling\\_list/default.asp](http://www.indianamedicaid.com/ihcp/mailling_list/default.asp). This service sends an e-mail to subscribers when new communications are posted to the IHCP Web site.